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# *the* MODERN HOSPITAL

VOLUME 46

MAY 1936

NUMBER 5



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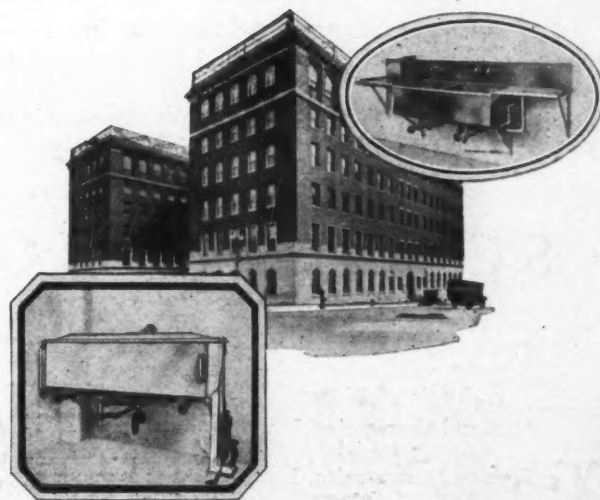
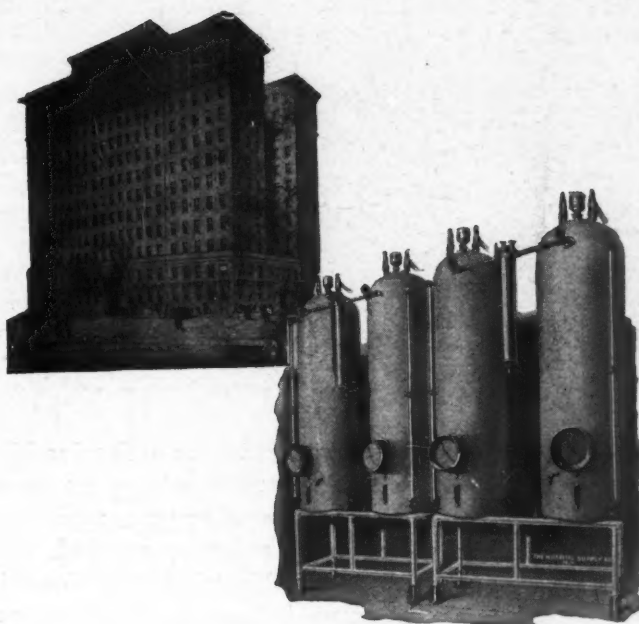
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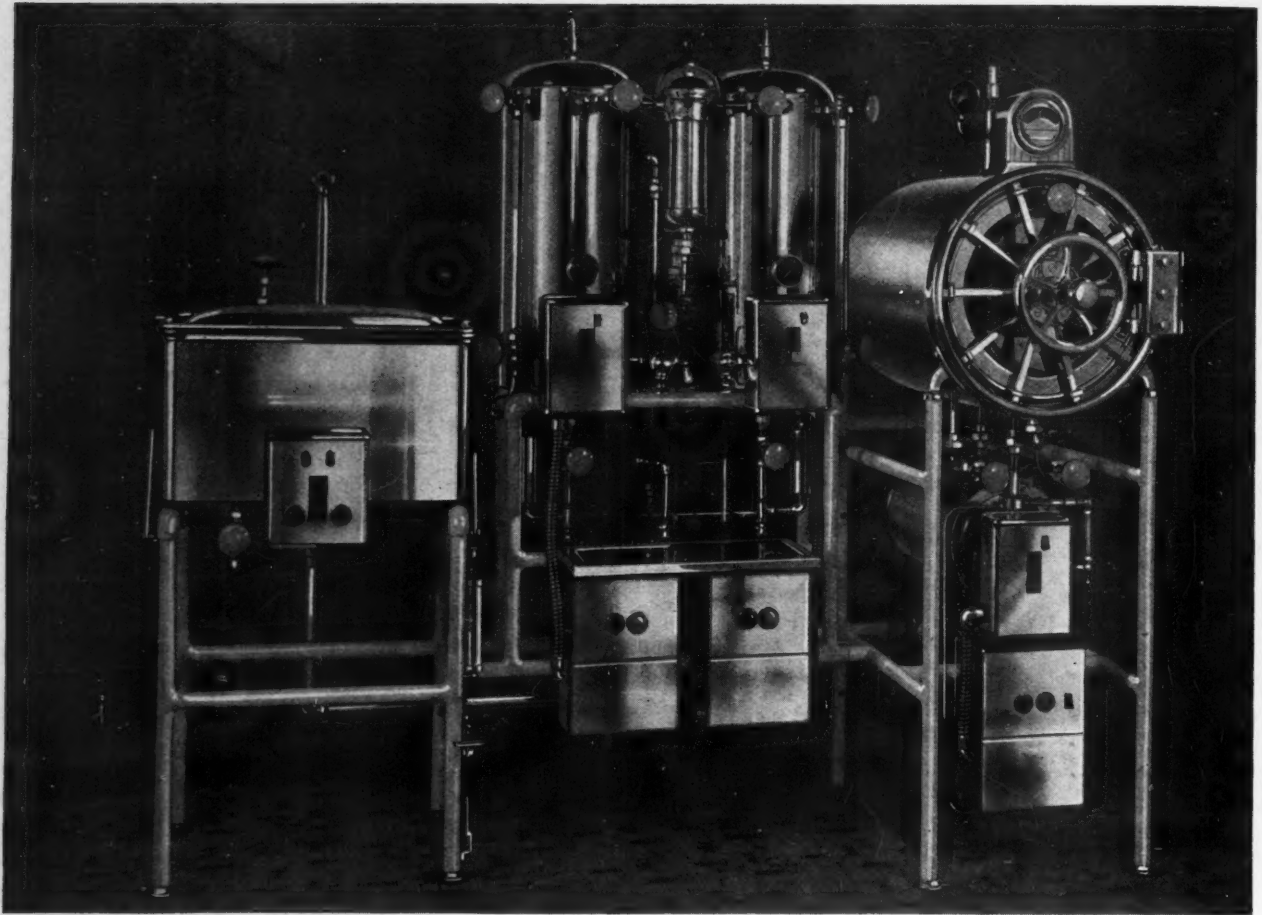
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For May, 1936

Just in Passing—

COVER PAGE—U. S. Naval Hospital, Philadelphia, Pa. W. T. Karcher and Livingston Smith, Philadelphia, Architects. Photograph by courtesy of *Architecture*.

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ONE of the curious hallucinations that certain hospitals used to entertain was that they were saving money if they admitted a large class of probationers and then weeded out the unsuitable ones at the end of four or six months. More careful analysis shows that to be an expensive way to buy maid service. But how can the hospital tell in advance which candidates will make acceptable nurses?

An interesting answer, or at least partial answer, to this question has been found by the nursing schools of New York State which are using a psychologic testing service to aid them in picking their students. With almost uncanny accuracy the tests, when interpreted, prophesy the chance of success of the prospective students. Next month Edith Margaret Potts who administers this central testing service for the hospitals will describe its results.

IN A report to the house of delegates of the American Medical Association the judicial council of that organization declares that some of the marriages between hospital service and medical service ought to result in divorce. Like many of those who take refuge in the divorce courts, the judicial council may not have given due consideration to all aspects of the situation. Next month Dr. Michael M. Davis will call attention to some factors in the relations between the profession and hospitals that are sometimes overlooked. His article should be read by all doctors but particularly by anesthetists and radiologists.

*Published the first of each month by*

**THE MODERN HOSPITAL PUBLISHING CO., Inc.**

Charter member Audit Bureau of Circulations

**919 NORTH MICHIGAN, CHICAGO—Telephone, Superior 6402**

**NEW YORK OFFICE—101 Park Avenue. Telephone, Ashland 4-2445**

**SUBSCRIPTION—United States and Possessions, and Canada, \$3.00. Foreign, \$4.00.**

**Single copies (current), 35 cents. Back copies, 50 cents to \$1.00.**

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Printed in U. S. A.

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**P**ROSPECTIVE authors of papers for professional journals, attention! If your writings find hard sledding from cold-blooded editors, the trouble may not be with the content but with your manner of expression. Here's help for you. Dr. Richard M. Hewitt, director of the division of publications of the Mayo Clinic, has set down out of his wide experience some simple rules. They will help you to write the kind of papers that are direct, clear, accurate and, hence, a joy to an editor's heart. Doctor Hewitt's article will appear next month.

**I**S THE undergraduate nurse a student? That sounds silly, doesn't it? Actually, however, it is a practical question when it is asked of workmen's compensation boards. If she is a student and not eligible for compensation then premiums should not be paid for her. If premiums are paid, then the administrator must be assured that he is buying protection for his student nurses. A. M. Calvin decided that the situation merited study and so he made inquiry in every state. The results of his survey will appear next month.

**W**HEN a sailor's appendix begins to act up and he is 3,000 miles from shore, what can be done for him? If he is fortunate enough to be in Uncle Sam's navy there, is a great deal that can be done—and done quickly. Next month Captain Lucius W. Johnson, U. S. N., will tell the story.

**W**HEN the small hospital goes to build its budget—but do small hospitals build budgets? Probably many of them do not. But doubtless all of them will begin immediately when they see how easy and direct a process it is. Dr. B. W. Black and Dr. G. Otis Whitecotton will explain it all next month.

**A** NEW trick for keeping kitchen employees interested in keeping kitchens clean will be described next month. It has been tried in the modernized kitchen of the Methodist Hospital, Indianapolis, and according to Rev. John G. Benson seems to be successful.

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## FLASHES FROM THIS ISSUE:

"An effort should be made to interest the members of outstanding law firms in the community in the need of the hospital for endowments, for when wills are being made opportunities sometimes arise for making suggestions along these lines." *Page 48.*

"The scrubbing of air is one of the latest and greatest advances in surgery, probably as significant as any development in surgical technique." *Page 64.*

"Agriculture has an interest in hospitals and clinics as a part of a larger health program and urges that a study of health facilities be one of the problems presented to state planning boards." *Page 41.*

"Charitable hospitals in their efforts to meet the demand for more and more service cannot escape reasonable operating deficits which the community is expected to meet." *Page 60.*

"Fire and exit drills as ordinarily practiced in schools or factories cannot be conducted in hospitals." *Page 65.*

"The opportunity for recreation and occupation afforded hundreds of men and women is the most important contribution of a dairy farm to a mental hospital." *Page 71.*

"Correct temperature for cooking and storing does more than make food appetizing for waste is reduced and there is less danger of food contamination." *Page 86.*

"One of the first objectives of any finance committee must be to define an investment policy." *Page 49.*

"In those hospitals in which an experienced fireman cannot be employed to act as fire marshal, this position should be filled by a member of the staff in authority, and he should devote a definite portion of his time to the conduct of that office." *Page 66.*

"Dishwashing machines have kept pace with other items of kitchen equipment in contributing features of significance in sanitation and health." *Page 88.*

"The dangers of extreme economic retrenchment are many and serious, but they are not as perilous as are the unbecoming ways of acquiring seemingly easy money for the purpose of increasing the hospital's income." *Page 59.*

"Group intern conferences and frequent friendly discussions of patients and their needs with the medical administrative officer are of the utmost value." *Page 78.*

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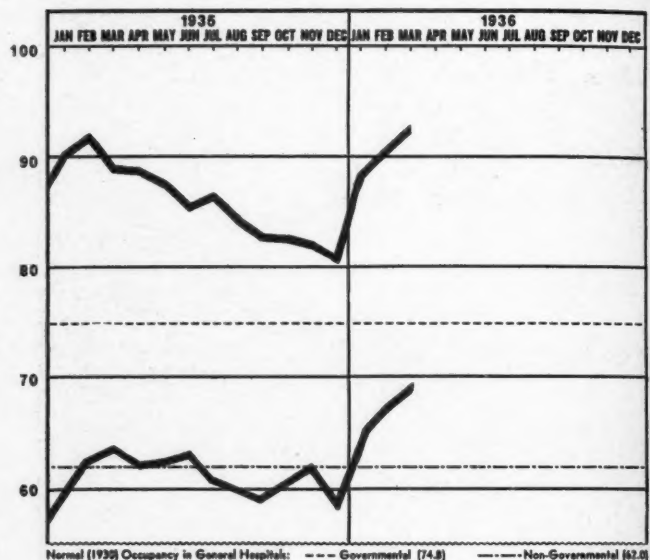
# The Hospital Barometer

Again in March the reports of occupancy in voluntary hospitals show a substantial gain over February, 1936, and over March, 1935. The tentative figure for March is 5.5 points higher than for March last year and actually 10 points higher than March, 1934. This is the highest occupancy that the voluntary hospitals have reported since this compilation was begun in 1933. Of course, seasonal factors influence occupancy in the early spring, and the figure for the government hospitals is also up. However, it is only 3.9 points higher than last year.

New hospital building projects fell off somewhat in the period from March 24 to April 20. Twenty-seven new projects were reported of which twenty-five report costs of \$4,232,966. Of these one was an alteration to cost \$50,000, seven were nurses' homes to cost \$1,341,000, and nineteen are additions to existing hospitals of which seventeen report costs of \$2,841,966.

The upswing in hospital building is marked in the first four months of 1936. In 1934, 127 projects were reported during the four-month period with costs of \$21,456,700 given for 114 of the projects. 1935 fell off considerably reporting only 72 projects for the first four months, the costs for 55 of which totaled \$10,277,500. This year 161 projects have been reported. The costs for 154 of these amount to \$30,656,000.

The general wholesale price index of the *New York Journal of Commerce* gained slightly but consistently during April. After a preliminary drop, grain and food both advanced appreciably, grain moving from 77.3 on March 30 to 81.2 on April 20, and food prices rose from 76.7 on March 30 to 80.3 on April 20 (1927-29=100). Textiles and fuels both dropped very slightly in the four-week



period between March 30 and April 20. Building materials continued to gain consistently. The *Oil, Paint and Drug Reporter's* price index for drugs and fine chemicals indicates a slight loss for the past few weeks.

Industrial activity advanced somewhat during March, according to the National Industrial Conference Board, and further improvement was noted in the first two weeks of April. The total number of unemployed workers in March, 1936, was 9,649,000 showing a decrease of 2 per cent from the preceding month and a decrease of 3.9 per cent below March, 1935.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals <sup>1</sup>		1935												1936		
	Hospitals	Beds <sup>2</sup>															
			March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March		
<b>Nongovernmental</b>																	
New York City <sup>3</sup> .....	68	15,194	74.0	70.0	75.0	72.0	66.0	62.0	62.0	67.0	69.0	66.0	71.0	71.0*	71.0*		
New Jersey.....	56	9,772	66.0	65.0	66.0	64.0	62.0	60.0	60.0	62.0	63.0	62.0	66.0	70.0	70.0*		
Washington, D. C.....	9	1,791	70.5	69.8	68.7	70.6	68.2	62.0	63.9	68.3	68.3	63.0	70.8	77.5	78.4		
N. and S. Carolina.....	103	6,332	64.9	62.3	64.6	66.8	65.7	66.3	65.7	64.4	63.3	59.1	63.9	67.1	67.6		
New Orleans.....	7	1,146	50.1	46.8	50.9	58.3	57.1	58.2	55.1	53.3	55.8	50.8	58.3	56.9	62.5		
San Francisco.....	16	3,098	67.4	69.5	66.4	67.4	62.4	63.9	63.9	66.7	70.2	65.2	71.9	75.6	71.7		
St. Paul.....	6	716	55.9	52.3	48.8	51.7	46.4	49.1	48.5	46.6	50.7	49.0	56.7	57.2	61.1		
Chicago.....	26	5,179	61.9	58.8	55.9	54.7	54.5	53.8	53.6	54.7	54.9	52.8	56.5	61.4	64.5		
Cleveland.....	5	572	62.0	63.6	65.7	63.4	63.2	63.4	58.5	61.7	62.3	60.6	66.5	68.3	75.5		
<b>Total<sup>4</sup>.....</b>	<b>296</b>	<b>43,800</b>	<b>63.6</b>	<b>62.1</b>	<b>62.4</b>	<b>63.2</b>	<b>60.6</b>	<b>59.9</b>	<b>59.0</b>	<b>60.5</b>	<b>61.9</b>	<b>58.7</b>	<b>64.6</b>	<b>67.2*</b>	<b>69.1*</b>		
<b>Governmental</b>																	
New York City.....	17	12,042	103.2	104.6	105.6	100.4	103.6	93.2	91.7	85.8	86.5	87.3	95.1	100.2	98.2		
New Jersey.....	4	2,122	84.0	85.0	84.0	77.0	79.0	79.0	76.0	84.0	78.0	76.0	80.0	84.0	84.0*		
Washington, D. C.....	2	1,596	76.3	72.7	69.4	67.4	68.4	69.5	62.9	60.4	60.4	62.9	71.4	73.3	68.9		
N. and S. Carolina.....	13	1,358	68.5	65.8	68.6	68.1	68.7	72.3	68.0	66.9	65.4	63.8	71.4	73.2	74.0		
New Orleans.....	2	2,227	130.4	130.8	132.8	138.8	149.0	143.1	140.9	138.5	137.4	127.8	130.0*	141.3	169.8		
San Francisco.....	3	2,255	77.1	80.3	77.3	72.3	72.0	71.3	79.5	76.8	79.1	81.1	83.5	83.4	79.2		
St. Paul.....	1	850	77.8	75.8	75.2	74.5	67.3	63.4	61.5	65.0	68.6	66.6	94.9	85.4	84.8		
Chicago.....	1	4,000	93.9	84.2	86.0	84.5	83.5	80.5	80.4	81.7	80.2	79.5	83.3	86.0	82.8*		
<b>Total<sup>4</sup>.....</b>	<b>43</b>	<b>26,450</b>	<b>88.9</b>	<b>88.7</b>	<b>87.4</b>	<b>85.4</b>	<b>86.4</b>	<b>84.0</b>	<b>82.6</b>	<b>82.4</b>	<b>81.9</b>	<b>80.6</b>	<b>88.7*</b>	<b>90.8</b>	<b>92.8*</b>		

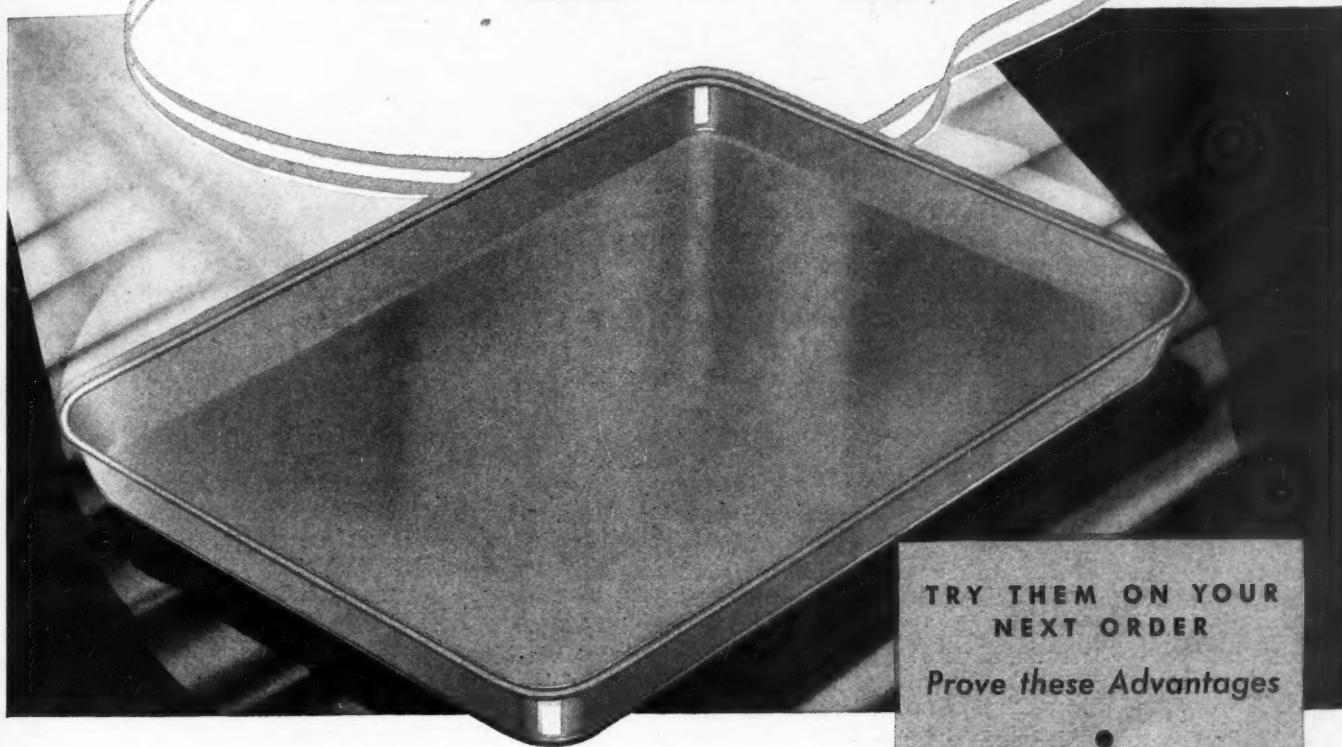
<sup>1</sup>Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. <sup>2</sup>Including bassinets, in most instances. <sup>3</sup>Includes only general hospitals. <sup>4</sup>The occupancy totals are unweighted averages. These averages are used in the chart above. \*Preliminary report.



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- ALCOHOL-PROOF • STRONGER
- CAN'T BLISTER • ECONOMICAL
- NO CRAZING • NO BREAKAGE
- CAN'T PEEL • NO BAD ODOR
- HARDER • CIGARETTE-PROOF

"The Trays that KEEP SMILING"

ALUMINUM IS FRIENDLY TO FOOD

## "Wear-Ever" ALUMINUM

THE STANDARD: WROUGHT OF EXTRA HARD, THICK ALUMINUM PLATE

# The Editor Talks It Over

● Now is the season in which an endeavor is being made to replenish many community chests. The attention of the public is sporadically thus called to the needs of the hospital. The enthusiasm of those interested in solicitation and of those concerned in the cause of the hospital is fanned to a white heat. At the conclusion of the campaign public concern about the hospital wanes. For another year the business of this important public utility excites but little general interest.

Why may not the cause of the hospital be presented in an interesting fashion throughout the whole twelve months? How can the concern of the public in regard to the future of its charitable institutions be maintained throughout the whole year? Perhaps some adaptation of the hospital exhibition which has rather commonly become a part of community chest drives might be adopted. Hospital exhibitions on visiting days, well directed publicity, pamphlets setting forth the progress of the hospital's work are but a few of the methods by which community chest interest might be transposed into a sustained effort throughout the whole year.

● May is the graduation month in many schools for nurses. Oliver Wendell Holmes once remarked that "Anniversary must be the saint of this country because he has so many birthdays." The graduation day for nurses should be made a gala event. It is well for the hospital executive now to ask himself what he proposes to do to make welcome parents and friends of the members of the class. It is usually the former who by saving and hoping and planning have made possible this glad event. The ceremony itself might well be made one of great dignity, of solemnity. Gaudiness and an atmosphere of the circus ring have no part in this event. As for the nurse herself, she deserves that the hospital spare nothing to make this, her great day, a memorable one.

● Self-assurance has little place in the life of those who care for the sick. The physician who prides himself upon being competent to treat all types of disease is too frequently seen

pompously parading hospital wards. Dr. Benjamin Rush, a signer of the Declaration of Independence, a man of great eminence in his profession, was sure that bleeding and purging were the cure for yellow fever. He boasted that of the hundred patients which he had seen in one day none had died. This remark is a surprising one when it is considered that Dr. Rush's formula for the treatment of yellow fever consisted of ten grains of calomel and ten grains of jalap. This eminent physician suffered two attacks of yellow fever himself and survived.

As to drugs which are sure to cure, unfortunately there are but few. Many have as little to support claims for their efficiency as did Dr. Benjamin Rush. Medical humility is a quality to be sought by all doctors, and, incidentally, humility in the presence of vital administrative problems is equally a desirable virtue.

● Do you ever stroll about the grounds of your hospital on a quiet sunshiny Sunday morning? Then disorder appears particularly disturbing. If the spring is just arriving, the areaways and other out of the way corners may still contain the debris deposited there by the swirling gusts of winter. The garbage disposal plant or the hospital greenhouses may deserve a visit. An unsightly plot unused and neglected but comprising the chief view of a patient's room or ward may call for cleaning and grading. The quarters occupied by the minor help of the hospital may be inspected. Plans for reconditioning the staff tennis courts may now be made. Mayhap the executive may be repaid for his efforts by discovering the first crocus peeping from the ground or a May rose just ready to burst from the bud.

● Do you have one member of your staff who is never satisfied with anything? If he is a surgeon and if the catgut is all right, are the scissors dull or the sponges too small? Does this man try your soul, so that your sleep is made vocal with speeches which you plan and caustic comments which you formulate to overwhelm the objector?

Such a character is indigenous to almost every hospital. He is often a blessing in disguise.

The worst disease to which the administrator is heir is "hospitalitis"—contentment with present routine and accomplishments. To become "rutted" is fatal, but the complainer is the cocklebur, which will surely if not painlessly save your institutional soul. Take him to dinner; get his outlook on hospital work; convince him, make him convince you that both the executive and the surgeon have but one purpose—improvement of hospital care of the sick. Such a physician is a constant antidote for hospital provincialism.

● Dr. C. L. DeMeritt in a recent issue of the *Atlantic Monthly* discusses hospitals as they are. As a visiting urologic surgeon, the writer's viewpoint is of interest as representing that of a more than average staff attendant. His comment in regard to the lack of privacy in the average public ward is as true as it is interesting. Many sensitive souls are disturbed by their goldfish-in-a-bowl ward experiences. Perhaps many ward patients are less offended by "flimsy curtain" partitions than are others. The author of this article might have also mentioned that frequently patients are placed in large wards because of insufficient nursing personnel and because in such accommodations more nursing hours can be brought to each bedside. It is far better for the sick to be well nursed in a large ward than forgotten in a de luxe single room.

Doctor DeMeritt calls attention to various types of staff organization and personality. He does well in pointing out that the higher the scientific vision of the staff, the more likely will be the presence of well filled private suites. To seek patients on a commercial basis is often to defeat the very purpose of such an effort. Full-time staff service, of course, is advisable. When politics enters the hospital door, science flies out the window.

Such articles are constructive in their tendencies and certainly point to an aroused interest on the part of a hitherto more or less complacent medical profession in the development of newer and better hospital practices.



# Looking Forward

## A Momentous Step

**D**URING the years from 1912 to 1920 an active but unsuccessful campaign for compulsory health insurance was carried on in the United States. This campaign was built largely upon European precedents and apparently gave but little recognition to the dissimilarities between European and American methods of medical practice.

During the twenties little was heard about health insurance in the United States. With the advent of the depression, however, both those who buy medical services and those who provide them became less satisfied with existing economic arrangements. Then came the report of the Committee on the Costs of Medical Care in 1932. While the majority report of the committee recommended only voluntary health insurance, a group within the majority went further and came out for the compulsory form. The principal minority group in the committee could not recommend either form, but did urge local experimentation. Two members of this minority also recommended compulsory insurance. In the intervening years both medical and lay groups have given much study to the whole question of a better economic relationship between patients and their doctors and hospitals.

Discussion of health insurance, whether voluntary or compulsory, has often been featured by more heat than light. The proponents have claimed that it was the best available solution to the economic difficulties of medical practice and that the errors and shortcomings of European plans could be avoided in this country. The other side has declared that health insurance would demoralize medical practice and has sometimes denied that there are any important economic problems to solve.

The arguments have up to now been purely theoretical. Last month, however, a step was taken that should help to clear the atmosphere. As reported in the news columns, the legislature of British Columbia has enacted a compulsory health insurance bill which will cover hospital as well as physicians' services for a majority of the wage earning population of the province. The act will probably be in operation before the

end of 1936. Substantial latitude is left to the health insurance commission to work out details subject to the approval of the provincial government.

Hospital executives in the United States and Canada will watch with keen interest the development of compulsory health insurance in British Columbia. If it proves a failure there, demand for it will tend to subside elsewhere. If, however, without lowering professional standards, it succeeds in providing more and better health service to those of small incomes and provides decent remuneration to physicians and hospitals, other provinces and states will undoubtedly follow suit.

## Flood Heroism

**R**ECOGNITION for public service rendered is due those hospitals which overnight leaped to the aid of their communities threatened by the angry onrush of flood waters. To care daily for a handful of new patients not critically ill is a leisurely task compared with calmly and efficiently meeting a community calamity. Basements, corridors, storehouses, even garages were utilized to house the sick and the homeless. Vaccines and sera were supplied to prevent disease, the devastating sequel of floods. Nurses and doctors toiled tirelessly forgetful of night and day. Emergency corps organized by the administrator risked life and limb to succor the needy. The hospital again has proved itself the stalwart first line of defense against flood, famine and disease.

## Sense Versus Sentiment

**T**HE cause of the hospital is not strengthened by a lachrymose appeal to the public for support purely on the basis of sentimentalism. While often splendid endowments have sprung from a purely humanitarian urge there are surely other grounds upon which an institution should stand or fall. It is just and proper that the fortunate should assist the unfortunate—the privileged, the underprivileged.

It cannot be denied that the appeal to the heart is often the hospital's strongest asset. To play upon the strings of sentiment by picturing the plight of sick and homeless children, of hopeless and helpless old age has its place in the heat of a community chest drive. But it is the sheerest bad judgment continually to place the hospital in the beggar class, with hat in hand and palm extended, asking alms.

A high official in a great industry recently remarked, "A corporation which derives generous benefits from community life must be willing to bear the corresponding burdens." He might have truthfully continued by stating that no corporation or business, great or small, can prosper in a community in the absence of high health levels. No prosperity will continue unless curative and preventive medicine can present to employers of labor those with strong and well heads and hands. The French failed to build the Isthmian Canal because a tropical disease was there rampant. General Gorgas built the canal because he conquered both lay official ignorance and opposition and the yellow fever bearing mosquito.

Hence the efficacy and fairness of an appeal for hospital support based solely on cold economic statistics should never be overlooked. The hospital is necessary not only to alleviate physical suffering but also to make possible the conduct of business and the maintenance of transportation.

## Hospitals as Vendors

**H**ERE and there ill feeling between physicians and hospitals fitfully flares up and then is extinguished by the cooling waters of calm judgment. A few months ago there was introduced in the New York State legislature a bill known as the Moran Act which made it an offense punishable by fine or imprisonment for a hospital to realize any profit on the professional activities of any specialty department. The hospital was thus forbidden to pay the roentgenologist, for example, a salary and by reason of fees charged for x-ray service do other than break even or suffer a loss on the work of this department.

Even though this bill was not reported out of committee, its implications are plain. It charged that hospitals profiteer on the services of physicians who are impotent to defend themselves. If this be true it should be strenuously opposed both by the doctors themselves and by all fair-minded institutions. To engage the x-ray director on the basis of a specialty consultant who

charges the patient a fee for each plate reading would no doubt not only lessen the use of this valuable aid to diagnosis but work a hardship on the patient. It would hardly seem as if this represented a solution to the problem. Moreover, in the large majority of instances a state law is hardly necessary to guarantee fair play on the part of the hospital with so important a colleague as is the doctor.

This bill while failing of adoption because calmer consideration proved it unnecessary may have served a purpose by directing attention to the need for a review of all personnel contacts with the hospital organization.

## Reasonable Care and Skill

**T**HE law requires in malpractice proceedings that the plaintiff prove that a physician did not exercise reasonable care and skill. Moreover, this type of care has in it something of a local comparative nature. The skill and care exercised by others in the community are often employed as a standard to measure the type of service rendered by the accused.

But neither the hospital nor the physician must be satisfied with mediocrity. Poor service by a neighbor does not justify a similar service by a near-by hospital. Today's public demands superservice.

To be eternally dissatisfied with institutional accomplishments is a healthy state of mind. To be provincially convinced of the presence of near perfection is to stagnate.

## Hospitals, Doctors and Sponges

**T**OO long have hospitals complacently accepted the protection from prosecution which their charitable nature assures them. In many states they are actually given immunity by statute from suit for supposed or real injury as a result of malpractice by their physicians or nurses. But upon every hospital worthy of the name rest obligations as binding and exacting as any set by legal requirement. The hospital is morally at least, responsible for the acts of its agents.

A California court recently held that a physician failing personally to count laparotomy sponges is guilty of negligence, should one be lost in the peritoneal cavity during the course of an operation. This is a significant ruling. Obviously the surgeon cannot interrupt his operation to count the sponges which he has employed



before closing the abdominal wound. But the hospital cannot stand guiltless before the public should an accident occur unless it has provided the surgeon with well trained nurses who are continually drilled in the technique of sponge counting. In the above instance, the court ruled that while such precautions had not been fully taken, yet the surgeon failed either to require that the nurse make such a count or to perform the same himself.

The institution's responsibility in such matters consists in exercising unusual care in granting surgical privileges only to those highly trained surgically and insisting that all adhere to the recognized rules of procedure in safeguarding the welfare of the patient. If it does otherwise it cannot stand guiltless before the court of public opinion even though machinery does not make possible its deserved punishment by a court of law.

## Protecting the Hospital's Charter

IN VARIOUS places and ways the public is expressing a growing suspicion of eleemosynary charters because they have been abused by certain institutions. Newspaper editorials, legislative proposals and private conversations indicate that the long established privileges of institutions operating under them are now threatened.

The eleemosynary charter is one of the most beneficent inventions of man. It is designed to encourage citizens to pool their efforts for the common good so as to make them more effective. To do this it grants privileges and immunities which are not available to other types of organizations and gives wide latitude in the exercise of functions.

Unfortunately, however, up to this time state control over the eleemosynary corporations which it has chartered has been vague and weak. Abuses have multiplied until they threaten the position of the legitimate charitable organizations. The best defense of these legitimate organizations is a self-imposed acceptance of the responsibilities inherent in such charters.

What are these responsibilities? First, such a charter should be granted only for public service for which there is definite social need. Included without question would be religious and educational institutions, institutes of scientific learning, art institutes, libraries and museums, hospitals, clinics and institutions of public health, and all relief agencies of a general character. Second, the service should not be discriminatory

but should be for the general good. Specialization is, of course, permissible and, where other facilities exist, is desirable provided it does not in fact amount to discrimination. Third, the institution must exercise scrupulous care that no one actually profits by its operation. Fourth, the institution should be extremely punctilious in accounting for its funds and efficient in its administration.

In actual fact today every one of these obligations is somewhere violated or disregarded. Eleemosynary charters are given to institutions that are not actually for public service or, if nominally so, produce no significant social results. There seems to be little excuse for granting eleemosynary charters to secret societies, some fraternal organizations, political and social clubs, and propaganda organizations of fanatical minorities. Many such institutions are in fact discriminatory and benefit a selected few while most of the people are entirely or partially neglected. Investigation and regulation of charitable institutions are lax and there is no effective check on efficiency.

If eleemosynary institutions are to continue to enjoy tax exemption, a wide discretion regarding their activities, freedom from state and federal supervision and the right to appeal to the public for funds it is time they cleaned house. The public will not continue indefinitely to grant privileges as important as these if they continue to be abused. Hospitals should join hands with other proper eleemosynary institutions in rewriting the laws so that they will discriminate effectively between socially useful and unworthy institutions.

## What Is Behind the Scalpel?

THE reputation—the good name of the hospital should be behind each stroke of the surgeon's scalpel. It is the hospital which guarantees to the public that none but highly competent physicians are permitted operating room privileges. No matter how much some institutions may attempt to evade the issue, the fact remains that every operation performed, every prescription compounded, every dietetic tray prepared should be certified by the hospital as the products of the activity of highly skilled persons.

Nor should the willingness of the patient to employ an untrained surgeon provide any excuse for deviation from such standards. The hospital is morally, if not always legally, responsible for every act of its personnel.

# Rural Medical Facilities—A Vital

By M. L. WILSON

Assistant Secretary of Agriculture

ANYONE who has lived on a farm or in a small town can recall instances that bring home forcefully the need for better medical facilities in rural areas. An accident, a serious illness that does not yield to usual treatment or complications in childbirth often demand skill and care that are found only in some kind of medical center.

Perhaps I should say right here that I do not profess to have the knowledge of medical matters necessary to define just what kind of medical service a town of 1,500 people should have. Obviously the population of the area to be served, the financial resources, the attitudes and many other factors must be considered carefully before any decision is made. That, I leave to the medical profession, health officials and community leaders.

The U. S. Department of Agriculture is directly interested, however, in the health conditions of rural families. In the last analysis the whole program of work of the department is aimed at the betterment of farm life in this country, and surely health is a first consideration in measuring a well rounded satisfying farm life.

## *What Census Figures Show*

Census figures also urge us to guard the health of our farm boys and girls. The American city has always depended upon youth from the farms and villages. This dependence is more marked now than ever before. For every two adults in our cities only one and one-half children are being reared. In the country the number has fallen to two and one-half, but even so the surplus in the country must supply the deficit in the cities or we will face serious social consequences.

Several years ago the department published a bulletin<sup>1</sup> on rural hospitals presented from the community planning point of view. The department, with its interest in all rural institutions, is keenly interested in the furtherance of better medical service for farm folks.

As a part of the rural housing survey made in 1934 a study was made of the available hospital facilities in order to show the present situation so far as hospital services to rural groups are concerned. It was our hope this would contribute to the background data to be considered by state

planning agencies in setting up a comprehensive health program, in which hospitals are an important part. We strongly urge that any program for rural hospitals be planned in connection with the other available health services for the community. Not only is it important that the size, cost and permanency of the health organization be thought through carefully from the economic point of view as well as from the point of view of the needs of the community, but that the community facilities be planned in relation to those of the region and state.

The department has for many years made a positive attack on the rural health problem through the extension service. Home demonstration agents work with rural homemakers, bettering home conditions in a variety of ways. They furnish suggestions for year-round supply of foods as the foundation for diet adequate for health, and they also give training in the selection, preparation and sanitary handling of food. They and the women in their home demonstration clubs, many of them mothers with school and preschool children, often assume leadership in promoting and demonstrating the value of such measures as school lunches, health education and physical examinations in rural schools, and they often sponsor and assist preschool clinics.

The home demonstration agent helps make the people of the county health conscious and develops proper attitudes toward preventive measures in the homes. The report of Dr. Philip Van Ingen at the medical section of the White House Conference on Child Health and Protection showed that rural families in certain areas made a better use of health facilities than urban families, in spite of the greater difficulty of accessibility, and that as a whole the rural use of health facilities was surprisingly high.

Rural boys and girls in the 4-H Clubs have adopted two slogans of "Make yourself your best exhibit," and "Grow into a fine club member." These have led to the widespread adoption in many states of health practices by club members.

<sup>1</sup>Nason, Wayne C.: Rural Hospitals, U. S. D. A. Farmers' Bull., 1485.



# Part of a Total Health Program

## *Agriculture and Hospitals Have Interests in Common*

The health rules have popularized physical examination not only for club members but for other children of school age, and have set up a standard of health that creates interest in both preventive and corrective measures.

Home demonstration agents serve as contact points between the homemaker and the health workers of various types. Many a school county nurse has been appointed because the home demonstration agent saw the need and organized the demand for this service. Many other nurses have had their first introduction to the rural constituency through home demonstration club women.

These agents also have helped to develop in the women an appreciation of the need for better health service, more frequent examination of children, use of the available facilities for vaccination against smallpox, immunization against diphtheria, and the need for prenatal, labor and post-labor care of mothers. They work closely with the health agencies and when no health officer is available have brought to the attention of the state tuberculosis committee tuberculous cases needing care and pointed out the needs of crippled children to the agencies in the state responsible for their care.

Now we have made another step forward nationally. The Social Security Act makes special provision for health services for rural areas. It provides aid for maternity and child care and makes special provisions for crippled children, all in cooperation with state agencies, and all monies to be used according to plans set up in the states and approved by federal agencies. This seems to offer an opportunity to forge ahead with the planning of rural medical facilities as a part of a total health program.

Health is a national concern. A national health program will probably be required if hospitals are to reach rural areas. Through the Social Security Act and extension service we have developed plans for federal-state cooperation which do not remove local responsibility. We should like to see hospitals developed where the community

needs and can support them and clinical facilities provided where the population is not large enough to support a hospital. In connection with these, whichever is developed, there should be provision for certain health safeguards.

Even the clinics should have sufficient space for emergency care and operation in cases of accidents, and for temporary care where patients cannot be moved immediately to the nearest hospital. Such health centers would dignify and centralize the health activities of a county or group of counties, would serve as an office of information and as a station where emergencies could be met and needs for longer service be sorted out. Where the hospital facilities are not available locally and the patients need specialized or longer care they can be routed to the necessary hospitals. The location of either clinic or hospital should be thought through with the demands of the community in mind and planned in relation to road conditions and accessibility to larger and specialized hospitals. Agriculture has an interest in hospitals and clinics as a part of a larger health program and urges that a study of health facilities be one of the problems presented to state planning boards.

### *How "Medical Stations" Might Function*

A plan suggested in the final report of the Committee on the Costs of Medical Care for the villages and distinctly rural areas, which contain about 38 per cent of the population, calls for a series of "medical stations." Each station would be under the supervision of a complete medical center or an affiliated branch, and would consist of one or two physicians, a dentist and a few public health nurses or trained nurse-midwives. These stations would rely upon affiliated branches or medical centers for facilities or services which the station personnel could not supply. Occasionally traveling specialists would visit the medical stations to treat special diseases. Through the linkage of medical stations to affiliated branches and of affiliated branches to community medical centers, the entire population would be provided with complete, adequate, supervised medical service, including the necessary hospital facilities, yet a large degree of autonomy and responsibility would be retained locally.



# A Hospital Gets Down to Business

By RAYMOND P. SLOAN

**I**N TREATING of business affairs, hospital or otherwise, a direct approach to the subject seems expedient. Therefore, without benefit of preamble, the door of the Lutheran Hospital in the Hamilton Heights section of New York City is deliberately opened upon an inviting hallway, bounded on the west by a waiting room and on the east by an office and information desk.

"Will the visitor kindly wait just a few minutes?" The request comes from the office of Charles O. Pauly, managing director, followed by the suggestion, "Perhaps you would like to be looking over some of our recent reports?" What better opportunity for gathering facts about a small general hospital (108 beds and 22 bassinets, to be exact) which has made a place for itself in metropolitan life and derives its chief support from within its own four walls.

A dip into the past discloses the fact that the hospital has a birthday coming along soon, a very important birthday, its twenty-fifth. Already plans are under way for a gala celebration next November with silver trimmings, of course.

Back in the early days, a group of Lutheran

doctors and druggists started a medical social service under the name of the District Medical Service of the Society of the Lutheran Hospital. One member of this group, a doctor, made a bequest of \$20,000 with the condition that the money be spent for the erection of a hospital to be known as the Lutheran Hospital of Manhattan.

So the years passed, bringing greater call for its services and the need of a new building. Some of those in charge of its affairs advocated a change of location. By this time the Negro population formed a black fringe along its eastern boundaries. Started as a community project, however, it was decided to maintain it as such despite the possibility of an Ethiopian invasion. In 1931, three floors of the modern six-story structure were opened into which patients were moved from the old wing where they had been housed during building operations.

The hospital's endowment today totals \$34,000. Of this, however, \$20,000 has brought no return for the past three years. Its support, therefore, is from personal donations and gifts, membership dues from contributions of the women's auxiliary



Overshadowed by towering medical centers whose vast resources are widely publicized, obscured by the progressive growth of a large metropolitan center, what place has the small hospital in relation to its surroundings? From what source can it hope to draw sustenance? What chance for survival has it in the maelstrom of big city life? The answers are found in this *Little Journey* which takes us along Convent Avenue in New York City to One Hundred and Forty-Fourth Street just around the corner to the Lutheran Hospital of Manhattan



and a Junior Aid Society, but principally from its own operation.

From 1927 to 1936, its progress can be traced by studying income and expense figures with their attendant losses and gains. One fact these figures clearly show—that income alone without economic management of expenses cannot produce the desired results. Behind these figures themselves may be traced problems common to any hospital regardless of its size or location. At one time there seemed no other way out than to close its doors. Fortunately, new ideas saved the situation.

During his years of service on the board of directors, five of which were spent as president and chairman of the building committee, Charles O. Pauly reached the conclusion that an applied business administration is as important to the ultimate success of an institution as the professional procedure of operations. Although willing to listen, his fellow board members were more interested in being shown. They decided that Mr. Pauly was the man to show them. In 1932, they persuaded him to assume complete charge.

During the two years that followed, operating deficits gradually were wiped out. Not only was the income from patients made to cover all costs, but there was a substantial net return above the actual balance of income and expense accounts.

INCOME AND EXPENSE FIGURES, 1927-36			
	Income	Expenses	Loss
1927.....	\$223,418.51	\$225,946.28	\$ 2,547.77
1928.....	204,582.04	219,150.11	14,568.07
1929.....	194,721.44	211,108.20	16,379.26
1930.....	149,007.16	184,094.95	34,997.79
1931.....	86,333.70	117,350.98	31,017.28
1932.....	128,764.28	134,498.46	5,734.18
1933.....	69,831.06	90,089.90	20,258.84
			Gain
1934.....	127,425.95	123,013.49	4,412.46
1935.....	171,956.34	157,130.35	14,825.99

Significant, too, is it that these results were obtained during a period when economic conditions made necessary a large amount of free work and part-pay patients.

Similar progress was effected in promoting greater harmony within the organization. Staff problems were smoothed out to the satisfaction of all. The prestige of the hospital spread beyond

the immediate community into lower Manhattan across the river to New Jersey and on the other side to Long Island. In addition to its regular staff comprising leading doctors and surgeons, among whom are the two past and present presidents of the New York County Medical Society, requests began to be received from others in the profession who would use its facilities. A small hospital had made its way in big city life.

No further time is permitted for jotting down notes from annual reports. It is Mr. Pauly in person.

"I am not a trained hospital superintendent," he explains frankly, "but many years of business experience in buying, selling and expense control, together with supervision of all kinds of employees and a successful record of creating and maintaining harmony in various organizations furnished me the needed qualifications to overcome operating deficits."

#### *A New Era Begins*

The first step in establishing successful business relationships is to define clearly the position of each individual or department not only in regard to his or its own individual function but to the organization as a whole. Business procedure which marked a new era for the Lutheran Hospital centers on the following premises.

"A hospital superintendent or managing director should have full authority in fixing and regulating rates and fees for income, full direction and supervision of all employees, their salaries and working conditions and the ability to control expenses.

"The board of directors should provide funds for physical needs of the institution such as buildings, equipment, maintenance and repairs. Three distinct qualifications are necessary to a successful operating board. First, the retired man of means with a spirit to give; second, the business man of prestige to influence others in hospital needs; third, the man who will contribute time and actual service.

"The medical staff should have full supervision in the treatment and care of patients. The relationship between doctor and patient in regard to professional services and fees should not be interfered with by the hospital. A mutual understanding between the doctor and the hospital management under which neither pursues a selfish monetary procedure will result in genuine harmony."

Few changes were made at the start of the new business régime. There ensued a period of watchful waiting during which a close study was made of each department, one at a time, always with

the assistance of the person in charge. The professional approach was left to others. This was business—centering upon the question of what could be afforded in actual dollars and cents and with a watchful eye always on economies.

Buying in quantities was eliminated, and the department store practice adopted of buying only as needed. Where formerly five or ten drums of alcohol were purchased and stored for future use, today but one drum is bought. Instead of stocking some hundred or so oxygen tanks, ten or fifteen are bought as required. No sacrifice to price is necessary, except possibly on one or two items, and any additional expense involved is more than compensated by saving space which might be put to better use, and by lessening the deterioration of supplies. Two or three large storerooms have been abandoned and in their place two small ones installed, one for medical supplies and the other for the dietetic department.

Food is purchased by the dietitian in the same manner under the supervision of the managing director. It has been found possible to buy one crate of oranges at just as good a price as a larger quantity. The secret lies in confining the business to one account rather than distributing it among many, that is, not buying promiscuously. It is surprising, too, how it simplifies bookkeeping.

#### *Checking Competitive Prices*

Time, and a little patience, may be required to convince the manufacturer or jobber that they will receive sufficient annual business to justify a quantity price, with deliveries as needed. Personal contact with the heads of the concerns facilitates the procedure considerably. It is never well to take too much for granted, however, and a frequent check-up on competitive prices is merely good business.

Is every inch of hospital space being used to the best advantage? Are employees, for example, occupying quarters that might produce some revenue?

Several years ago the Lutheran Hospital housed its nurses and other employees in two homes it had acquired. These were not adequate and some had to be housed elsewhere at a cost of \$5 a week each or about \$250 yearly. When the new hospital was erected, accommodations for twelve were provided on the top floor, but a short time ago it became apparent that this space might more profitably be diverted to patients.

About \$3,120 would be required to pay rent for the nurses outside. A house adjoining the old section of the hospital was procured, however, at a carrying charge of about \$1,000 or approximately 30 per cent of what it cost to board the



girls elsewhere. A sound business proposition, unquestionably, but even more, a factor in promoting satisfaction within the organization through providing livable quarters.

It is always advisable to start from the bottom and work up. Mr. Pauly began with the laundry. This was inadequate, and still is, but it is hoped that the time is not far distant when additional equipment can be installed to effect further savings. As it stands, however, laundry expenses in 1928 totaled \$8,171.86. During 1935, this was reduced to \$3,160.12.

It had been the practice, it seems, because of the limitations of the hospital laundry, to have all nurses' uniforms and other handwork done outside. The charge was \$0.35 for each uniform. A hand ironer was engaged and given comfortable working accommodations in the basement of one of the nurses' homes. She not only cares for the nurses' uniforms to the satisfaction of all, but in addition does doctors' coats, gowns and any other handwork which may be necessary.

Is it possible to reduce the number of people employed in the kitchen?

Then there is always the question of whether just as efficient service cannot be had at less cost.

To return to 1928, total expenses of the dietetic department at the Lutheran Hospital were \$50,495.31. In 1935, they amounted to \$46,109.91 notwithstanding the higher cost of food. Nor does the 1928 figure include interest charges on investment, stock, etc.

It has been the procedure to have the trays



*It's the little things that count in the children's ward—hangings with nursery rhyme figures done in bright colors—an occasional print on the wall—table and chairs just the right size for the small guests. Who couldn't smile in such cheerful surroundings? The lower picture shows the pathological laboratory.*



prepared in the kitchen and sent to the floors by electric dumb-waiter. With the purchase of new electric food containers the food will now be sent to the floors and served from pantries direct to the patient with the assistance of the nurses. This innovation is not regarded solely as an economical measure but is one that contributes to better service. Good food and appetizing food service should not be sacrificed for savings. "The best foods

obtainable with diversified menus have helped materially," Mr. Pauly emphasizes, "in building a popular reputation for the hospital."

Despite economies attendant upon installing cafeteria service for nurses and help, such a plan has never been considered. This, it is felt, would not be good business. Too much depends upon the satisfaction and contentment of employees who are entitled to table service. This is mentioned as an indication that not everything is judged purely from the dollars and cents standpoint.

#### *Use of Oil Fuel Proves Economical*

There is always the problem of fuel, light and heat. Before the hospital became established in its new building, coal was used as fuel, and there was much discussion over the use of oil as a substitute. It was finally agreed to try it. Two low pressure boiler units and a high pressure steam boiler were installed in the new building with a 5,000-gallon tank placed under the sidewalk in the street. Despite the fact that there is about 30 per cent more cubic feet in the new hospital than in the old, heat, light and power for 1928 cost \$10,445.38 as against \$10,295.10 in 1935, with much more electrical power consumed.

Similar check-ups and economies were applied to each department, at no sacrifice, however, to its efficient conduct. Housekeeping expenses and salaries totaled \$10,984.27 for the year 1928, and \$6,983.09 for 1935 despite the increase in work. Part-time workers care for the nurses' home, for example. One of these homes houses girls employed on night work exclusively. Their rooms are cleaned in the evening by part-time helpers. Others clean certain hours during the day when the girls are on duty.

A slight increase over 1928 is shown in salaries and expenses attached to the maintenance department. This figure totaled \$3,297.88 as compared with \$3,956.49 for last year. It must be remembered, however, that there is today 30 per cent more property area to care for.

The hospital pay roll numbers 90, with 45 on the nursing staff. Average daily patient census in 1935 was 75. This will undoubtedly show some increase during the coming year with the opening of the sixth floor to patients when the total capacity will be 143 beds and 22 bassinets.

The business angle enters again in the matter of establishing rates. About two years ago the ward rate was changed from \$3 to \$4. Considerable question was raised as to the advisability of such a policy in view of existing conditions. The revision was made, however, with beds still filled to capacity. The children's ward rate is \$3.

The same business attitude is maintained in the conduct of the clinics—eight of them and all exceedingly active. A charge of 25 cents is made for each treatment with the exception of eye and dental work for which 50 cents is received. During 1935, 4,528 treatments were given for which no less than 90 per cent paid the amount required. The hospital receives no funds from the city and employs no social worker. This record is maintained only by careful control, although free service is always available where it is necessary.

Once sound business procedure has been established, there remains the need for careful supervision and check-up. Forms and reports are simple, eliminating all nonessential red tape. Requisitions are put through by department heads only, comprising supervisor of nurses, dietitian, housekeeper and the two laboratory technicians. The original goes to the supplier, one copy goes to the bookkeeper, another is kept by the requisitioner, while a fourth copy, a tissue, remains in the book as a permanent record. The original and duplicate receive the signature of the director, who watches closely for any increases which may require explanation. Food costs, for example, he checks carefully each month to determine trends up or down.

#### *Planned Effort Wins Subscriptions*

Under the supervision of a man regularly employed for the purpose, letters are constantly going out soliciting subscriptions. These supplement telephone calls, and are also used to arouse interest on specific occasions. An Easter appeal, for example, produced \$120 during the first seven days of April. During the course of a month some two hundred letters are mailed to carefully chosen people who it is believed might be interested in helping. Each telephone call is followed by a letter signed by the managing director. The number of contributors in 1935 totaled 350, two hundred of whom had never given to the hospital before. It is expected that the total for 1936 will be close to 500. Last year these efforts raised \$8,179.50. The cost involved was about \$1,562.22.

To close with, here is a plain business statement signed by Charles O. Pauly: "The success of this combined business and professional policy is manifest in many ways. The medical staff, the nursing staff and the entire organization are content and happy.

"Its success is further proved by the many complimentary verbal and written expressions of patients, their families and friends. It is reflected as well in the receipt of contributions from old and new friends which again proves the axiom 'Nothing succeeds like success'."



# Nursing an Endowment

By JOHN C. MACKENZIE, M.D.C.M.

Superintendent, Montreal General Hospital, Montreal, Que.

*The endowment fund is a recognizably important part of the hospital and its accumulation and management should be the subject of study by hospital authorities. Doctor Mackenzie here points the way to success in handling hospital trust funds*

**A**N ENDOWMENT fund or foundation is that portion of the hospital's funds which is subject to trusts attached by the donors, the interest only to be used, the capital to be kept intact. In no instance and under no consideration may the principal itself be used for any purpose whatsoever.

Where gifts or bequests come to the institution without specific attachments they may be disposed of in one of three ways: (a) placed to the credit of the general endowment fund, when the total amount will be invested in securities to produce revenue for the hospital, the capital being kept intact; (b) used for the purchase of such capital assets as buildings or plant equipment with the capital amount kept intact by funds set up for replacement; (c) credited to the surplus account to which operating deficits may be charged.

It should be the policy of the institution to dispose of unmarked bequests in the first of these three ways. When gifts are left unrestricted, it is usually the assumption of the benefactor that such monies as he leaves will go to swell an endowment fund, and this belief, though not stipulated in the deed of the bequest, must be carefully considered in the disposition of the bequest. Some institutions have a rule that any donation over a certain amount goes to swell the general endowment fund. Once an endowment always an endowment must be an inviolate rule.

Endowments fall into two main categories, general or unrestricted and restricted or specific.

The revenue derived from the first is to be used for any interests of the hospital to aid in offsetting the operating expenditure. On the other hand, revenue from the restricted class can be used only for the specific purpose for which the endowment was given. It is obvious that the most acceptable type of endowment is unrestricted and if opportunity allows it should be suggested to a donor that he give his bequest to the general endowment fund of the institution rather than assign it to a specified purpose. This allows more elasticity in utilizing the revenue.

Bequests or legacies accruing to the endowment funds should be valued at their market value on the date they are placed to the credit of the endowment fund, and this value becomes the book value for future definition. Only in exceptional circumstances, as, for example, the aftermath of the 1929 debacle, may the book value be written down; otherwise it should remain as originally entered. It is unlikely that a situation will arise to warrant the writing up of the book value.

## *Two Obligations Must Be Accepted*

Persons who are charged with the administration of such a fund must realize that they are acting in a trust capacity and that they have imposed on them two principal obligations: (1) to invest the principal of the fund so that the maximum annual benefit will be derived consistent with safety; (2) to expend the annual benefit derived in accordance with the donor's instructions if specific instructions be given, or for general purposes. There is seldom any requirement, however, that the total revenues or benefits be expended in any one year and it is often desirable that the revenues of the fund be accumulated. This, however, does not change the obligation that the revenues eventually be used for the expressed wishes of the donor and for no other.

A drive for a specific endowment fund, such as for the nursing school, should be made on the grounds of the merits and needs of that specific project. The virtue and necessity of endowments for the department or function must be definitely laid down and clearly demonstrated to those who

are philanthropically inclined. The procurement of such an endowment will depend largely on how adequately those intimately associated with the department can demonstrate a need for the added revenue. The whole plan for present and future requirements, as far as can be foreseen, should be carefully studied beforehand and the capital sum so arrived at made the objective of the drive.

The call for initiating general endowment funds or increasing them should be continuous. The best way to sustain this continuity is to have the hospital's reputation as a good hospital always before the public. The general public should be kept constantly informed of the high standard of work that the hospital performs and how it fulfills its responsibility to the community for charitable work. Information in respect to accidents or unusual cases with the beneficial results obtained should be freely supplied to the press who are always willing to publish a story which contains real news. There should be the fullest co-operation between the hospital and the press at all times.

The annual report should give a full and complete picture of the year's work of the institution, both through written reports of the officers and department heads and statistics that show the work of the hospital in general and in particular departments. Stress should be laid upon the amount of free and part-pay work done, with the consequent incurred deficit. An effort should be made to interest the members of outstanding law firms in the community in the need of the hospital for endowments, for when wills are being made opportunities sometimes arise for making suggestions along these lines.

#### *Enlist Interest of Public Groups*

Every effort should be made to interest public bodies, clubs and societies in the activities of the institution. Volunteers from such bodies as the junior league should be encouraged to work in the institution or in one of its departments. This may be done by volunteer work in the social service department, in the outdoor clinics, or as a set project of the league. There has been in operation for a number of years at the central division of Montreal General Hospital a canteen which provides lunches to free patients waiting over for afternoon clinics. Such a canteen can also charge those able to pay for the meals provided and the profit derived may be donated to the social service department.

Volunteers can also be invited to attach themselves to the social service department for case work in company with one of the regular social service workers. In this way the volunteer's in-

terest is aroused not only in the cases she may visit but also in the general needs and necessities of the underprivileged. These volunteers are given an insight into the living conditions of free or part-pay patients. The importance of this cannot be too greatly emphasized. By means of her contacts the volunteer can and will tell those who are in a position to aid the hospital financially of the work it is doing for the relief of the sick poor, and though it may be a "long shot" towards increasing the endowment fund one can never tell where the "back-fire" will come.

#### *Acknowledging Gifts*

In approaching those financially able to assist an endowment fund the fact that they may perpetuate their own names or the names of deceased relatives or friends should be kept in mind. This has a strong appeal to a certain type of person and probably its scope is broader than we care to recognize. Acknowledgment of such gifts may be made by the erection of suitable plaques or by engraving the names of benefactors, with the year and the sum donated, in a conspicuous place.

It is of the utmost importance that the personnel of the hospital always recognize that a patient is a patient, no matter what his financial status may be outside the hospital. By treating all patients with sympathy, tact, courtesy and understanding the hospital is going a long way towards making friends of those patients. Patients in the public wards can play their part in obtaining financial aid to the endowment fund, because, in this topsy-turvy world of ours, he who is poor today may be rich tomorrow. Furthermore, the poor patient may, by word or action, express to some wealthier person his enthusiasm for the work of the institution concerned and in this way influence the latter to become interested and give willingly of his funds.

It is a vital necessity that the hospital be recognized in the community as a good hospital. This can be achieved only if the hospital is actually so in deeds and results. Not only must the community be proud of the hospital but the entire staff must impress the community with the fact that they know it to be a good hospital. Often the attending staff may have an opportunity to encourage rich patients to donate funds to the hospital. The aid and influence of the medical staff should be sought, therefore, toward this end. The selection of outstanding men in the community as members of the board of directors gives the institution its hallmark and those men by their influence can do much towards increasing the funds of the hospital.

The general endowment fund can be constantly



augmented by means of procuring life governors whose initiation fees should be credited to that fund and their subscriptions added to the general revenue of the hospital. Constantly increasing the numbers of life governors augments the endowment fund and the revenue of the hospital and also serves to promulgate amongst the members of the community the name of the institution.

A finance committee of the directors or the board of management should administer endowments. The men comprising this committee should be chosen for the diversity of their interests, knowledge of business conditions and ability to render sound advice on business problems. They are responsible to the board of management for the whole financial set-up of the hospital and should hold meetings regularly, reporting to and obtaining the approval of the board of management for its actions. Much of the work of this committee will devolve upon the honorary treasurer or, if the institution is large enough, on the paid full-time treasurer. He will be responsible, under the direction of the committee, for surveying the business affairs of the institution and preparing the budget and financial reports. The finance committee will be responsible for investing endowment funds in sound securities, constantly surveying the portfolio of investments, and selling those which in the committee's opinion should be reinvested.

#### *A Comprehensive System*

In a recent paper on the administration of endowment funds, Raymond L. Thompson, University of Rochester, said, "A summary of the financial and business situation is usually presented and discussed as related to a monthly summary of our endowment assets, which sets forth both graphically and in tabular form the trend of endowment income, the fluctuations in market values as related to book values, as well as average yields at market values — all this information diversified by types of investments.

"As a corollary to this tabulation, we present the changes in market values by classifications of investments, the fluctuations in the average rates of income by types of investments, the profits or losses taken upon security sales during the month and a report indicating all purchases and sales of securities." It is evident that the system in vogue at the University of Rochester is a comprehensive one, much more comprehensive than could be profitably adopted by the smaller institutions for whom this present paper is written. Mr. Thompson does, however, point a way in which all endowment funds should be administered. His statements may be summarized as follows:

One of the first objectives of any finance committee must be to define an investment policy—just what type of investment is the institution going to purchase? When the institution is governed by the trustees act of the province concerned, the nature and the type of investment will be clearly defined, but where the institution is not subject to such restrictions the policy must be determined. In formulating such a policy the committee has two main objectives. First of all, a security which is within stable limits and not liable to fluctuate, and secondly, a security which will give as great a return in the way of dividends as possible. In adopting the policy the committee should give every consideration to a general plan of diversification of investment.

#### *Diversified Holdings Are Advised*

Diversification should be part and parcel of the finance committee's policy, not only in types of the same classification but also in various classifications, as for example into industrials, utilities, railroads, financial, government and realty, thus obviating the danger of losses that may come in the swing from prosperity to depression in any one particular classification. A suggested ideal arrangement made by an investment house in New York is as follows: bonds 50 per cent, preferred stock 10 per cent, mortgages 20 per cent, common stock, real estate and miscellaneous 20 per cent.

If the committee invests only in firstclass government or allied bonds, as pointed out by Doctor Warriner, a trustee of Lehigh University, it is accepting but a small share of the responsibility with which it is charged, for the reason that the income from an investment of this kind would probably produce, except in the case of a heavily endowed institution, insufficient income to meet its budgetary needs. In furtherance of this statement it is interesting to note that a composite fund made up of the investment of thirty colleges having 74 per cent of all investments of endowment funds of over \$50,000,000 is: bonds 49 per cent, preferred stock 7 per cent, mortgages 13 per cent, common stock and miscellaneous 29 per cent. The amount invested in equities (common stock and miscellaneous) in some colleges and universities is as follows: Lehigh, 7 per cent; Lafayette, 9 per cent; Yale, 50 per cent; Harvard, 30 per cent; Pennsylvania, 40 per cent; Swarthmore, 10 per cent; Princeton, 24 per cent; Columbia, 13 per cent.

The funds for investment should be divided into long term and short term securities so that certain securities can always be in a liquid state in order to take advantage of favorable business con-

ditions as they may arise. In the selection of securities for investment, advantage should be taken of information supplied by such statistical organizations as Moody's, Poor's or Standard Statistics. A finance committee should also agree that there should be set up in the books of the institution an investment reserve fund. To this fund is credited such profit as may be made by selling any investment. Similarly the losses developing from the sale of securities will be charged to this fund and it should be the particular function of the committee to keep a balance. This naturally demands that the committee keep a vigilant eye on the portfolio, for vigilance is rewarded by safety.

The committee should not consider its function and duties completed when it purchases firstclass bonds. Such a committee is not accepting its full responsibility. The procuring of as high a rate of interest on its investments as can be obtained is equally its responsibility in order to produce as great a revenue as possible for the institution.

To aid the committee and rid the institution of onerous detail it is advisable to hand all the securities for safekeeping over to a trust company which for a moderate fee will cut the coupons, collect the dividends and interest for the account of the institution, and make recommendations to the committee covering the retention or sale of securities in the portfolio. The final authority and responsibility, of course, must rest with the committee and on their judgment depends to a great extent the welfare of this trust.

It must be recognized that no matter how strong an institution or its finance committee may be, it cannot be expected to withstand fully all the conditions that have presented themselves to the financial world in the past three or four years or, for that matter, that may present themselves in the future.

The author records appreciation to Raymond L. Thompson, treasurer of Rochester University, for his kindness in permitting quotation from his article, "Care and Administration of Endowment Funds," in the Proceedings of the Conference of Trustees of Colleges and Universities on, "The Responsibilities and Problems of the Governing Board of Educational Institutions," April, 1935.

## Simplifying Maintenance and Repair

Dripping faucets, springless shades, loose screws, noisy chairs, loose weather stripping, or defective signal cords, can create a great deal of friction between the nursing and engineering department unless prompt repair is executed.

A good method for securing prompt repairs is to classify them in two groups: repairs which can be done on the division or ward without the use of large tools and unusual supplies; those which need large replacements or are taken to the workshop for major work.

Repairs in the first group are handled by the maintenance man in his regular morning rounds as he is provided with a small tool kit, containing pliers, screw driver, washers, felt chair tips and an assortment of screws. A repair book ruled in columns and giving date, repair to be made, name of head nurse, date and time of completion and name of individual making the repair is kept for each ward or division. The head nurse designates in the book each morning the repair requested. At the end of the month the book is inspected and the expediency with which repairs were made is noted. This saves stationery, ensures daily completion of work and prevents friction among members of the personnel through prompt service.

Repairs in the second group, those requiring workshop service or replacement of parts are made through regular requisitions sent daily to the administrative office for approval and collected by the engineer. At the end of each month all requisitions for such work are separated into two groups, finished and unfinished, and given to the hospital administrator, who can thus readily detect the efficiency of the maintenance department. A conference on unfinished requisitions is held with the engineer and

an investigation made of delayed purchases from manufacturers necessary for the speeding up of general work. This method gives the administrator a picture of the work accomplished in the department and the extent of minor and major repairs, shows whether there is sufficient personnel to keep the building maintained constantly and ensures more prompt service.—*E. Muriel Anscombe, F.A.C.H.A., Jewish Hospital, St. Louis.*

## What It Costs to Overheat

"It is better for a thermometer to read 68° F. than 70° F., says the Metropolitan Life Insurance Company in a health booklet entitled "Just a Cold." "Overheated rooms cause more colds than underheated," the booklet states.

In the studies of the New York Commission on Ventilation, it was found that an increase of 2° F. above normal room temperature brought a 70 per cent increase in ailments of the nose and throat.

Aside from the question of health, there is the item of expense. The table quoted below shows how costly it is to heat beyond 70° F.

<i>Temperatures</i>	<i>Extra Cost Over 70° F.</i>
71° F.....	3.1 per cent
72° F.....	6.2 per cent
73° F.....	9.4 per cent
74° F.....	12.5 per cent
75° F.....	15.6 per cent
76° F.....	18.7 per cent
77° F.....	21.9 per cent
78° F.....	25.0 per cent
79° F.....	28.0 per cent
80° F.....	31.0 per cent



# Entering the Third Decade

By ANNA D. WOLF

Director of the School of Nursing and Director of the Nursing Service,  
New York Hospital

THROUGH the activities of the education committee of the National League of Nursing Education under the astute leadership of M. Adelaide Nutting, the first edition of "The Standard Curriculum for Schools of Nursing" was published in 1917 and was revised, under the chairmanship of Isabel M. Stewart, in 1927, a decade later. The book has been reprinted seven times, and its sales have reached 10,000.

The purpose of the original committee was "to arrive at some general agreement as to a desirable and workable standard where main features could be accepted by training schools of good standing throughout the country . . . and gradually to overcome the wide diversity of standards at present existing in schools of nursing." These have remained the primary purposes of the curriculum in each edition.

## *Today's Needs Must Be Met*

The 1927 revision followed the remarkable and timely report of the Committee on Nursing and Nursing Education in the United States, and seemed necessary in order to keep the curriculum in line with the newer developments in the field of nursing. The changes that have gone on since that time in the social and economic world have brought concomitant changes in the lives and in the services of nurses. We are familiar with the advances in medicine which so largely determine the type of nursing demanded and place peculiar requirements upon the nurse of today. In the field of education we also find new knowledge which definitely affects our conception of nursing education.

The fact finding studies of the grading committee have been published and in its final report, "Nursing Schools, Today and Tomorrow," conclusions concerning the functions of nurses are clearly discussed. Attention is drawn especially

to this paragraph: "All professional nurses must have knowledge of the household arts; they must give expert bedside care to men, women and children suffering from all common types of diseases; they must be able to observe and interpret symptoms — physical, mental and social; they must be able to apply the principles of mental hygiene to the care of all sick people; they must take part in the promotion of health and prevention of disease and teach measures in the conservation and restoration of health; they must cooperate effectively with families, hospitals, health and social agencies and organized medical groups."

As persons engaged in the preparation of young women for the varied services of nursing in the community, it is obvious that we should take stock of ourselves, study our present situation and make such adjustments in our curriculums and in our methods of teaching as will prepare our students for the many demands made of them upon leaving our schools.

Another decade has almost passed and a revision of "A Curriculum for Schools of Nursing" has seemed imperative. The first step in obtaining this was to set up a working organization, therefore a committee known as the central curriculum committee of the National League of Nursing Education was appointed, together with a small steering committee to act in an executive capacity, both to be under the able chairmanship of Isabel M. Stewart, the former chairman of the education committee. Care was taken to include in the membership of the central curriculum committee representatives from the three national nursing organizations, including the presidents of each, the chairman or some member of their various committees relating to educational problems and members at large. Particular representation from state boards was secured and the state leagues appointed committees whose chairmen have given

1937 will see the second revision of "The Standard Curriculum for Schools of Nursing." Here is a glimpse behind the scenes, at the material, facts, ideas and traditions that will be incorporated by the education committee into this decade's revision

much time to the work done by the committee.

A large group of collaborators and consultants, specialists in the various fields of interest, physicians, hospital administrators and educational experts have contributed largely to the work of the committee. As reported by the chairman, "Most of the detailed work on the course outlines has been done by seventeen production committees, each composed of from five to twenty members, collaborators and consultants, making a total of about two hundred individuals. The chairmen of the production committees serve as members of the program of studies committee."

It can readily be seen, therefore, that the preparation of the proposed revised curriculum has been the thought and work of many individuals and that as far as possible the advice and counsel of those depending upon nursing as a service in the community, in homes and in hospitals, have had a share in it.

#### *Underlying Philosophy Is Sought*

Recent studies in nursing education and some of the more important trends in general and professional education were reviewed to discover, if possible, what they might contribute to our nursing program. It was evident that some underlying educational philosophy and aim, acceptable to the majority of those concerned with the education of nurses, would have to be determined, and the democratic or social philosophy was accepted in its general outlines and interpreted in terms of the adjustment of the student to the physical and social environment of the modern world.

Standards upon which to build the curriculum were determined on the basis that the school of nursing is organized primarily for the education of nurses and administered to carry out effectively its educational function on a professional level.

Specific standards as assumed by the committee relate further to the matriculation qualifications of the student. It has been recognized for some time that maturity is a greatly desired qualification for a student in nursing and it is believed that two years of general education beyond high school is an admission requirement toward which we should work as a goal.

The proposed curriculum built on this level specifies a two and one-half to three-year program for basic professional preparation with practice and class work included in a forty-four hour per week schedule. The committee assumes that the school will have available such financial, clinical and other facilities as may be required to put the program on a definite educational basis. This will mean the employment by the hospital of sufficient

graduate nurses and other workers to release students from hospital nursing service which is not needed in the educational program.

Students should pay tuition and other educational expenses incurred, while an equitable financial arrangement should be made between the school, student and hospital for the value of nursing services rendered.

The curriculum, as has been said, covers two and one-half to three years on the basis of a three-term plan per year, each term of sixteen weeks, or a four-term plan of twelve weeks each, with four weeks' vacation a year. Strict adherence to the suggested terms may prove impractical when planning the clinical practice periods, yet they are a useful guide. To hospital administrators the nursing practice time is of special interest. The length of the school week is five and one-half days or forty-four hours, with one and one-half days off per week. This program includes all regularly scheduled classes and nursing practice and provides sufficient time for study and recreation.

In the first four-months term of the first year, classes and laboratory run from twenty to twenty-two hours a week with no nursing practice. These hours of class are decreased to fourteen hours in the second term at which time eighteen hours a week of nursing practice is begun. In the third term classes are fourteen hours, practice twenty-two hours. In the second and third years classes average five hours every week and nursing practice thirty-eight or thirty-nine hours.

#### *What Proposed Course Includes*

In the proposed three-year course there are 1,200 hours of class and laboratory work and 4,288 hours of nursing practice as compared to 825 hours of class plus 200 hours of ward teaching and approximately 6,000 hours of nursing practice in the 1927 revision. The consideration of the time element is limiting and exceedingly dangerous, however, if the subject matter and its presentation are not considered.

The courses included in the curriculum are:

1. Service courses. These are preparatory to all other courses and include anatomy, physiology, chemistry, microbiology, materia medica, psychology, sociology and history and ethics of nursing.

There is nothing new or strange in this group except that possibly more emphasis is placed upon the psychologic and social studies.

2. Major professional or technical courses. These are concerned with the art of nursing and include a new course known as health conservation. Others in the curriculum are the nursing arts; nutrition and cookery; medical, including



communicable disease, surgical, pediatric, obstetric, psychiatric and home nursing. The practical application in actual nursing situations allows for real integration of the service courses. The approach to sick nursing through a knowledge of health is a change from our former plan.

3. Discussion groups. Students will be largely responsible for these and their content is drawn from the other two groups of study. This is a new development and should lend itself well to a better integration of all subject matter offered.

Effort has been made to combine short courses and to develop more coherent groupings of other courses. Material has been transferred from one course to another and a few new courses have been suggested.

The psychologic aspects of nursing that relate to the adjustment of the student herself and to the care of adults and children have been emphasized and the sequence culminates in a suggested program in psychiatry in the third year.

Public health and health teaching are incorporated throughout the course. The suggested programs of study and practice include elementary sociology, a social and professional seminar, nursing as health conservation and nursing and health service in the family.

More time was requested by nearly every production committee for the courses in the underlying sciences as well as clinical subjects. However, it was necessary to make a time limitation. No individual courses as set up have less than thirty hours.

Methods of teaching center around the usual lectures, class discussions, laboratory work and nursing practice with emphasis upon instruction at the bedside, the correlation of theory with practice and the integration of the various units of study.

#### *Test Questions*

It has been recognized by the central curriculum committee that the curriculum must be tested. The following questions should be answered.

Does the curriculum as a whole offer the best preparation for nursing? Will the sequence of study and methods of instruction and teaching assure us better nurses for community service? Are the individual courses adequate? Do they overlap? Are there nonessentials included? Could they be reorganized in different form for more effective study? Have we preserved sufficient time for the practice of nursing? Are the practice periods long enough for our students to gain the skill which will enable them to practice as graduates without immediate supervision? Does the practice offered give basic preparation in the major

clinical fields so that the graduate may have a choice in service? How can such a curriculum be operated? Is it administratively too costly for hospitals or other agencies to assume? What would be the best plan for its administration?

To a group of hospital administrators responsible for schools all these questions are exceedingly important. Perhaps the last three questions would be given first consideration as many administrators see in this proposed curriculum features which would largely preclude the use of students for the nursing service of hospitals. This would either reduce the quality and quantity of nursing care of patients or would require paid employees. These are well recognized facts. In some communities the proposed curriculum may be out of the question yet undoubtedly there will be certain features about it that will be helpful in determining policies of work and study.

#### *Critical Analysis Is Requested*

The central curriculum committee does not feel assured that the proposed curriculum is the optimum for our present requirements and it is seeking advice from all who will give time and thought to the consideration of its work. Specific plans for this have been:

1. To establish study groups composed of nurses, doctors and others interested in the various topics. Recent reports show that thirty-five states, the District of Columbia and Hawaii have organized five hundred groups made up of several thousand individuals, diligently studying the value of the courses.
2. To secure advice from leaders in general education in regard to the general conception, plan and construction of the curriculum.
3. To have forty-two selected schools of nursing actually try out some of the individual courses of study and offer their criticism.
4. To have the whole curriculum tried experimentally in one school.
5. To have special studies made in relation to plans for organization which would lend themselves best to such a curriculum.
6. To have a special committee composed of hospital and school administrators and lay friends study the problems relating to the administration of such a curriculum in various types of organizations.

All of these critical analyses and suggestions will give a great deal of useful information and opinion to the central curriculum committee which will be considered before publication of the final revision.<sup>1</sup>

<sup>1</sup> Abstracted from a paper read at the meeting of the New England Hospital Association, Boston.

# Someone Has Asked—

## *What Are Functions of the Medical Staff Aside From Patient Care?*

The extra-clinical functions which should be assumed by the medical staff are listed below with examples:

The members of the medical staff should serve in an advisory capacity to the governing body in medical-administrative problems (e.g. the appointment of a radiologist), and to the director in a similar capacity (e.g. the purchase of a new operating table); should teach residents and interns (e.g. weekly round table conferences or journal clubs), undergraduate nurses (e.g. courses in clinical subjects), and graduate nurses (e.g. postgraduate courses covering recent advances in each specialty); should supervise and encourage research problems, both clinical and preclinical, in conjunction with the house staff; should assist the hospital in maintaining adequate clinical records; should assist in preparing programs for staff meetings, and should cooperate with the hospital in projects of community health (e.g. preparation of pamphlets on health problems for distribution to the members of the public).—A. J. HOCKETT, M.D.

## *Should the Hospital Sell Drugs and Supplies to Its Personnel?*

An executive in a Mid-western hospital has asked this question. There are several aspects to the problem. There is a definite doubt in the minds of many whether the hospital should thus compete with supply houses offering such commodities for sale. The institution expects the support of near-by merchants, yet, with its low overhead and large scale purchasing power the hospital easily undersells local business houses even though it adds the usual 10 per cent as a carrying charge. Some even question the wisdom of furnishing prescriptions at or near cost to dispensary patients who may be able to pay a minimum sum for them to a near-by druggist.

The location of the hospital will determine somewhat the answer to this question. An isolated hospital should, perhaps, sell various sundries on a nonprofit basis to its patients and their friends. In a more centrally

located institution this policy might not seem wise. As a general thing, however, a hospital should be truly an institution not conducted for profit. In emergencies the hospital should, of course, supply to its staff any article needed.

It does not appear wise to adopt a policy of routinely furnishing goods and instruments to medical or nursing staff members at a price below that charged by community business houses. The purchasing of drugs on a large scale and the selling to staff members of these pharmaceuticals in the original containers at or near a cost price does not appear to be an accommodation which should be expected of the average community hospital.

## *Should a Small Hospital Have a Perpetual Inventory System?*

First let us define a perpetual inventory system. It is a written record of the receipt and issuance of hospital supplies, maintained in such a way that the written records indicate at all times the number of each item on hand. A perpetual inventory system can be partial or complete, that is, applied to a few expensive items or to all supplies.

A small hospital might well have a perpetual inventory of some items, but it probably would be expensive and confusing to attempt a perpetual inventory system for all supplies in an institution with less than 100-bed capacity.

A system of accounting or record keeping should not cost more than it is worth. Records are made for the superintendent and not the superintendent for the records.—C. RUFUS ROREM.

## *When Should a Hospital Conduct a Compensation Clinic?*

Staff members frequently request that a compensation clinic be added to the dispensaries conducted by the hospital and that the physician be reimbursed for his service to this type of patient. The location of the hospital will, in a measure, determine whether such a special clinic should be conducted.

If the institution is surrounded by

factories, this type of patient will not be infrequent. If it is in a residential section but few compensable accident cases will come to its clinic. If the bulk of this work is large these patients will probably be better treated in a special clinic. If it is small they may be handled along with other surgical patients.

Dependent upon various state laws will be the amount which the institution is permitted to charge for each visit. This will be from one dollar upwards. Some hospitals turn over 50 per cent of the income of this clinic to the doctors conducting it; others pay a flat honorarium which varies from \$50 to \$100 a month. It probably would serve to improve staff morale if some of the younger staff members could be moderately recompensed for service in the compensation clinic, particularly since these patients bring to the hospital fees in excess of the average dispensary charge.

Whether such a clinic be established at all and the plan under which the doctors work therein are matters wholly within the control of the hospital superintendent. There is little difference in principle between treating dispensary patients who pay twenty-five cents a visit and those that pay a dollar under the compensation laws.

## *What Is the Wise Procedure in Making Staff Appointments?*

Appointment to the medical staff of a hospital should be considered a privilege and an honor and should carry with it the solemn obligation to further rather than retard the service and the reputation of the hospital. For these reasons, staff appointments should be made carefully and only after adequate consideration. The procedure should be as follows:

1. Application should be made upon a standard application form, furnishing the following information: (a) name, addresses, age, place of birth, religion; (b) education—premedical, medical, year of graduation, standing; (c) internship and postgraduate training; degrees; licensure; (d) experience in practice and other appointments (if any); (e) membership in medical and other scientific societies; (f) contributions to scientific journals or at conventions; (g) references concerning ability and character; (h) agreement to abide by the hospital rules and regulations on appointment. This should be signed and furnished to the superintendent. Any particular specialty of interest to the applicant should be indicated.



2. The application should be referred to the credentials committee, the medical advisory board or another appropriate staff committee, for consideration.

3. If acceptable to the staff, the application should be forwarded to the governing body for final approval. The governing body should not appoint members to the staff directly or against the advice of the staff committee except under most unusual circumstances.

4. Appointment should be for one year only. Signature to abide by the hospital regulations, not to practice fee splitting, should be confirmed.

5. The chief of staff or the superintendent should have a conference with the new appointee to discuss his participation in staff work, also to arouse his enthusiasm for such general and vital matters as the support of medical staff meetings and activities, the development of scientific studies, the support of economy measures, the fostering of favorable public opinion.

6. A record of the doctor's work in the hospital, of his cases, his results, his scientific studies, his attendance at conventions, his evidence of cooperation and of his qualities of leadership should be kept by the administration. This confidential record is but fair to all parties concerned.—G. HARVEY AGNEW, M.D.

### *Shall Memorial Pictures Be Placed on Delivery Room Walls?*

In a certain Western hospital a contributor desires to construct an addition to the maternity suite for use as a delivery room in memory of his deceased wife. He has asked permission to place her picture with a suitably inscribed tablet on a wall in this room. The superintendent of this hospital asks for an opinion as to the advisability of this step.

It should go without saying that the delivery room suite should be so constructed that its walls, floors and fixtures can be cleansed with the greatest ease. Pictures on walls or inaccessible or out of the way spaces should be discouraged.

Memorial plaques or pictures may be placed in the wall so that they are flush with its surface and hence collect no dust, but it would be advisable to suggest that a memorial plate be placed on the door leading to the delivery room suite or better still added to the collection of acknowledgments which in most institutions is placed in the general waiting room.

With tact, the feelings of the prospective donor can be saved and his desire to honor a departed one gratified by diverting his interest into other and more proper channels.

In another institution it was proposed to place a blackboard on the delivery room wall to enable the surgeon continually to have before him the pelvic measurements of the patient under care. This practice is not recommended.

### *How Should Accident Cases Be Assigned to Physicians?*

Our method of handling accident cases that have no attending physician is to assign them to an intern the moment they are brought to our emergency department. If possible, we check carefully to see if they have any choice as to physician. If they do not, we consult a list of the members of our staff who have expressed their willingness to be called day or night to take care of these patients. They are rotated regularly. On our record, we keep the name of the patient and the doctor assigned to the case. The next accident case which comes in, we assign to the next doctor on the list. Great care is used so that all of these physicians will be treated exactly alike. Many of our older physicians do not care to be assigned to these cases. As a natural consequence most of the men on the list are younger men on our staff. This gives them splendid contacts and often patients which they would not otherwise secure.—R. A. NETTLETON.

### *How Are Patients Transferred From One Ward to Another?*

Transfers may be necessary or desirable for several reasons, the chief of which are: (1) convenience in care, as the segregation of surgical and medical patients; (2) convenience to the attending doctor in order to concentrate his patients; (3) convenience (or safety) in treatment—isolation or special technique cases; (4) comfort of others, "disturbed," offensive odors; (5) comfort of the patient—when objection is taken to the surroundings or more air or light needed; (6) change in the patient's financial status may make it desirable to move

him to cheaper or to more expensive accommodations.

Request for transfer should be made on a special form designed for the purpose, signed by the person requesting the transfer, concisely stating the patient's name and identifying number, the reasons for the transfer and whether the patient is fit to be moved. The transfer form is then sent to the office of the superintendent or of the admitting officer and if approved the transfer is ordered. As a check-up such transfers must be shown on the midnight census from both "discharging" and "receiving" wards. All documents relative to the patient must be transferred with him.

It may be desirable to obtain the concurrence of the attending physician, particularly in transferring under 3, 4, 5 and 6, when such a move might cause protest. The accounting office must always be consulted in moves made under No. 6.—GEORGE F. STEPHENS, M.D.

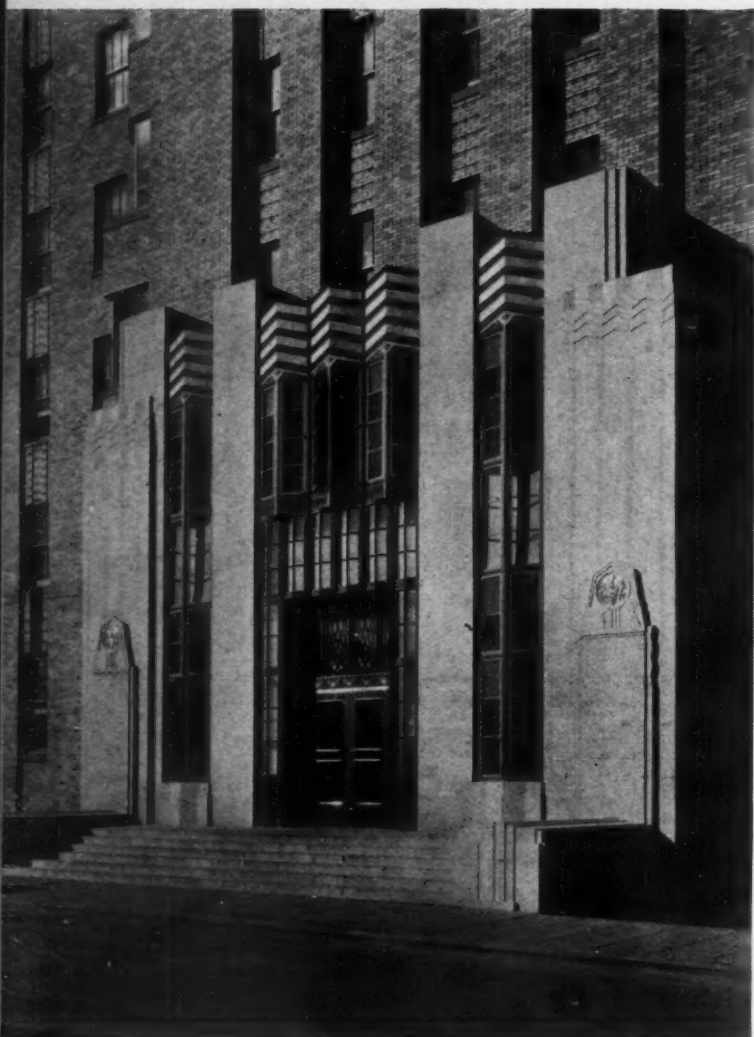
### *Should the Visiting Obstetrician Give Free Consultations to Courtesy Staff?*

This is a pertinent question. One of the chief trials of the hospital executive is to assure proper supervision of the activities of the courtesy staff. Most institutions restrict their practice in the hospital. Not all courtesy obstetricians, for example, are permitted to use forceps or to perform versions or other complicated maneuvers.

Some hospitals require that after the patient of a courtesy staff member has been in labor for a period of eighteen hours a consultant must be called. Many times the patient is unable to pay for such specialty service. The hospital is responsible, however, for the welfare of all of its patients. In not a few institutions the regular staff has volunteered its services in this capacity without a fee.

When a patient is able to pay for a consultation she should do so, but the assistance of a member of the courtesy staff by a more experienced obstetrician is often a life-saving measure, a request for which should not be delayed while the question of the recompense to the latter is being debated.

*If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue*



*Seattle's marine hospital is built on a hillside and commands a view of the mountains and of Puget Sound. The grounds have been terraced with rock gardens and there are acres of lawn.*



# Marine Hospital Climbs Aloft

By L. E. HOOPER

Medical Officer in Charge, U. S. Marine Hospital,  
Seattle, Wash.

THE Marine Hospital, Seattle, Wash., was completed and opened February 1, 1933. This hospital replaced one built many years ago at Port Townsend, Wash., and serves the entire Northwest district and the Territory of Alaska. It is operated by the U. S. Public Health Service and most of the patients are merchant seamen.

The site was donated by the city of Seattle and comprises about ten acres. It is on the crest of Beacon Hill in the center of the city and commands an unobstructed view of the Olympic and Cascade Mountains as well as of Puget Sound.

The architecture of this hospital is decidedly different from that of any marine hospital previously erected. The main building is sixteen stories from basement to tower, and is visible from practically all parts of Seattle. A better location could not have been selected as it is near the principal docks, easily accessible for seamen and yet the contour of the terrain assures permanently quiet and peaceful surroundings. Built on a hillside, the main entrance faces the south, and is two floors above the basement and ambulance driveway.

In addition to the hospital, there are nine sets of officers' quarters, and an attendants' building with forty rooms. At present, the nurses occupy the tenth and eleventh floors of the hospital, but a separate nurses' home was included in the original plan and probably will be constructed within the near future.

All buildings are attractively finished with orange brown brick in two shades, trimmed with bands of black. The grounds have been terraced

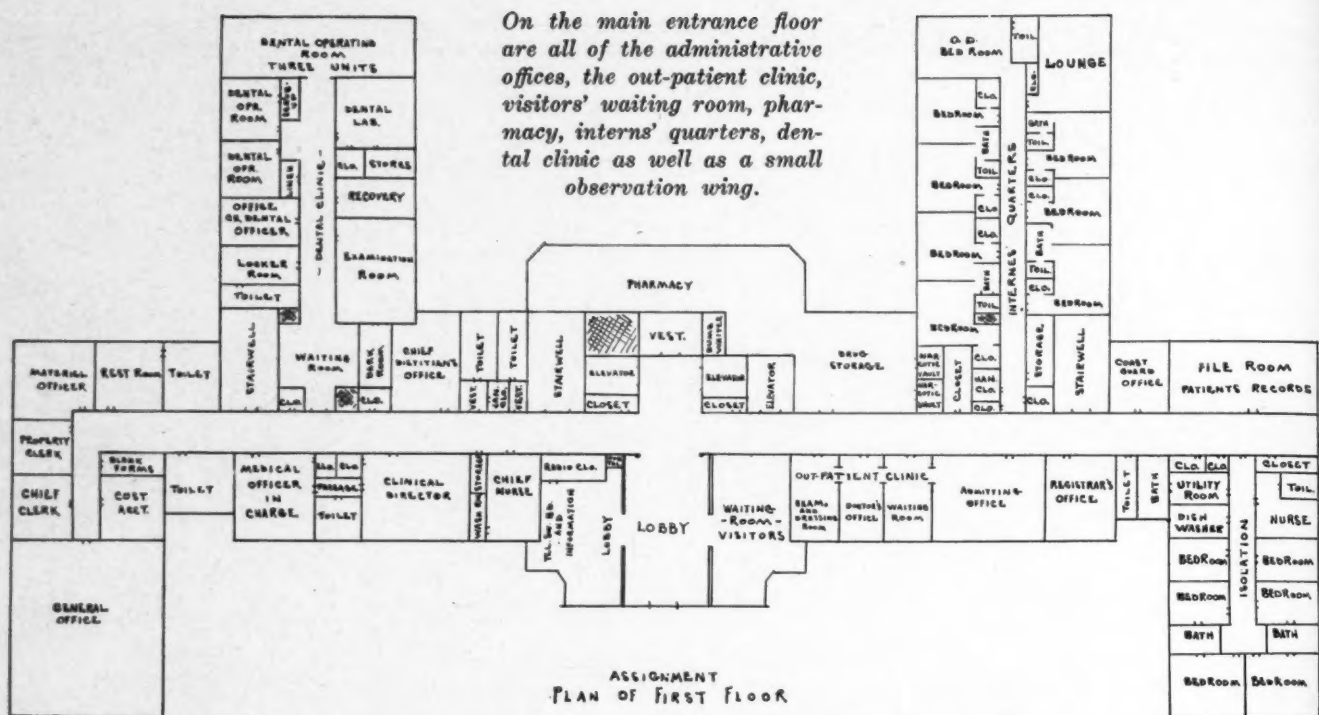




*The architecture of this imposing building is different from that of any other marine hospital. The buildings are finished with brown brick in two shades, trimmed with bands of black.*



*An interior view of the pharmacy located on the main floor facing the lobby. Left, a ward for fourteen patients, with 4 extra beds in the sun room.*



with rock gardens and there are about five acres of lawn.

On the main entrance floor are all of the administrative offices, the out-patient clinic, visitors' waiting room, pharmacy, interns' quarters, dental clinic and a small observation wing. Immediately below, on the ground floor, are the main kitchens, cafeteria, dining rooms and maids' quarters. The power plant, laundry, shops, storage space, morgue and necropsy room are in the basement.

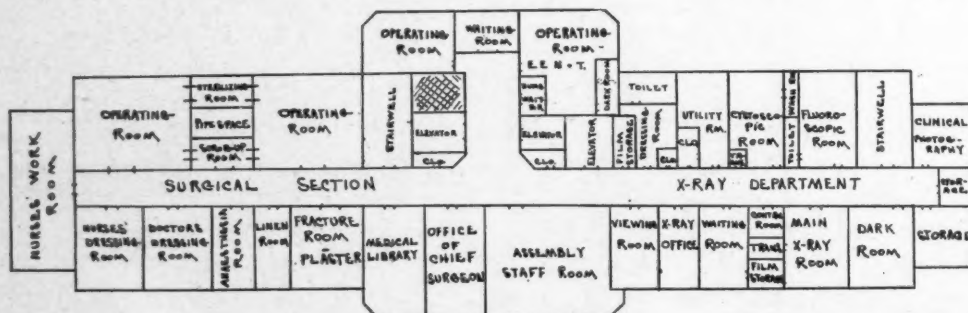
Seven floors are devoted to beds for patients. Of these, four are similar and each accommodates fifty-six patients. Most of the wards are small in comparison with other marine hospitals, the largest having fourteen beds with adjoining sun porches which can take care of four. There are twenty private rooms used for officers and seriously ill patients. Reading lamps and radio head phones are provided for each bed. A large recreation room with adjoining library and the physiotherapy department occupy the two wings on the second floor. Two solariums, one equipped with group treatment lamps, are provided on the eighth floor, which is occupied by tuberculous patients.

The ninth floor is devoted to the surgical section

and x-ray department. There are four main operating rooms with two smaller ones used for cystoscopic and fracture work. Spacious clinical laboratories take up the entire twelfth floor.

Each ward floor is provided with a centrally located diet kitchen with an adjoining dining room seating thirty-two patients. All food is cooked in the main kitchens on the ground floor and taken in electrically heated conveyors in the service elevator, which opens directly into each diet kitchen. Ambulatory patients serve themselves in the cafeteria on the ground floor.

This hospital has now been in operation for three years, and has proved to be satisfactory in every respect. From an architectural standpoint it is excellent, and modern equipment has been installed throughout. Among the principal features may be mentioned its compactness, all activities being confined to one building with many floors and no long corridors. This arrangement permits convenient grouping of different types of patients on separate floors. The present bed capacity is 400, and 379 patients are now in the hospital. The cost of construction of all buildings and all built-in equipment was about \$1,500,000.



*The ninth floor is devoted to the surgical section and x-ray department. There are four main operating rooms with two smaller ones for cystoscopic and fracture work.*



# The "Business" of a Hospital

By J. J. GOLUB, M.D.

Director, Hospital for Joint Diseases, New York City

THE hospital, like the whole country, is facing an economic crisis which, even at the risk of retarded growth, it must survive unscarred, safeguarding its traditions.

The dangers of extreme economic retrenchment are many and serious, but they are not as perilous as are the unbecoming ways of acquiring seemingly easy money for the purpose of increasing the hospital's income, through methods which tend to weaken the hospital's fabric. Specifically, hospitals should not enter into any profit yielding enterprise; trustees and administrators should be satisfied to heal the sick at a loss rather than to serve the well at a gain.

There are few fields of human endeavor in which the warmth of philanthropists and workers has changed less than that concerned with the care of the sick. Any failure to provide hospital facilities for the poor and the rich is naturally unthinkable. This task, which has always been the essential business of the hospital, is now threatened with relegation to a lesser rôle.

## *Side-Line Business Condemned*

Hospital policies and objectives should be so clearly in view at all times as to make it impossible to divert energy or thought to a channel that has no direct bearing on the healing of the sick and the prevention of disease. Hospitals thrive easily on the generosity of the people during periods of good business; to-day they must exert all their efforts in a legitimate direction to carry themselves over a period of economic upset, never in any case or at any time entering into business even as a side line.

To be sure, in order to render service the hospital must have a reasonable income and a balanced budget. It depends to a large extent on income from private patients and from those ward patients who can afford to pay the nominal ward rates. This source of income, as we all know, has been materially reduced by the effects of the depression. The hospital also depends on voluntary contributions which have alarmingly fallen off. There seems to remain but one way to save the hospital after all reasonable economy measures

*Meet the problem of your hospital's deficit by educating your community to recognize it as an honorable debt rather than through entering competitive business which will in the end destroy the hospital by breaking down its traditions, says Dr. Golub*

have been instituted, namely, to seek out additional and new sources of income.

The selling of toys, ice cream, sandwiches, drugs and cigarettes in the hospital's apothecary shop cannot be regarded as a sound venture, not only because it might distract the attention of trustees and executives from the time-honored work of caring for the sick, or because it would lessen the means of livelihood of neighborhood business men, or because business ethics and professional ethics would clash, or because hospitals are free from taxation, or because of the threatening dangers to the hospital's coveted traditions, but because of the reason that whenever and wherever there is an opportunity to make money there is likewise the possibility of losing it.

None of the hospital's money over which the hospital has merely a trusteeship should ever be used for any purpose other than the care of the sick. Should the thought occur to anyone that the trustees of a hospital could set up a separate corporation which would assume the responsibility for losses while the gains would be turned over to the hospital, it should be remembered that hospital trustees should, by the same token and because of the same interest, assume the responsibility for the hospital's deficit.

In the belief that by engaging in business the hospital could become, in a measure, self-sustaining, the supporters of the plan could build a veritable utopia. The city of Zenith would have its shoes manufactured, repaired and polished by

the Salvation Army; its clothing would be made by the home for aged; its printing and stationery would be supplied by the orphanage; its churches would be used as cinemas and its Y. M. C. A. and Y. W. C. A. as hotels; its health centers would constitute milk and dairy products purveyors; women's wearing apparel would be fashioned and sold at the headquarters of the D. A. R.; the post office would be in the G. A. R. building; the Boy Scouts would be the police; flower, drug, candy and cigar stores and restaurants would be controlled by the hospitals; the county medical society would have its seat at the city hall; the president of the local hospital's board of trustees would be the mayor and the hospital superintendent would be the budget director of the municipality.

Who would then be left to contribute to the hospital if there should still be a deficit or an emergency relief problem to be met, unless it were the undertaker whose business could not be conveniently assigned? He would still remain in business for himself, unless this utopian city could defy the forces of tide, taxes, and death.

And if anyone should ask what more could be expected of a perfect life among a harmonious citizenry in a utopian city, the reply would be that few would want the privilege of living in it. Few also would want to see any promise of hope held out for bettering charitable institutions, especially hospitals, on the basis of direct dependence on a business in which they might engage.

Honest competition, according to modern business methods, may be entirely fair, but the average business man might well be aggrieved at competition from hospital sources. He is unaccustomed to the idea of the hospital's being in a business other than that of healing. The neighborhood pharmacist or restaurateur will surely object, and justly, if the hospital even for a charitable purpose is responsible for a reduction in his source of livelihood.

#### *Contradictory Procedures*

An energetic hospital executive and progressive trustees seeking new sources of income in hard times might find this an easier way of meeting deficits than the usual, direct and time-honored appeal for contributions to warm-hearted citizens. At the moment they might conveniently forget or overlook or stubbornly belittle the serious consequences that are sure to follow, which might indeed shake the foundation and traditions of the hospital. On the first floor the hospital would admit a sick man as a free patient, while under the same roof, in the corner hospital store, it would sell a meal to the patient's wife, at a profit. Why hospital care should be given to the poor

without charge and food be sold to them by the same corporation at a profit is not easy to explain. The argument that profit from this source provides additional free service is unsound. It would be just as expedient, and would serve an equally useful purpose if the Salvation Army, for example, were to enter the hospital field, charge for hospital care, at a profit, and use the proceeds to feed the hungry, free.

#### *No Need to Be Ashamed of a Deficit*

Charitable hospitals in their efforts to meet the demand for more and more service cannot escape reasonable operating deficits which the community is expected to meet. The hospital which aims primarily at the avoidance of a deficit will soon lose sight of its proper objective. A deficit should be accepted when it results from the proper performance of the hospital's plain duty, and contributions should be sought from those who can afford to give. Surely nothing should be done which would wean people away from the support of charitable institutions. On the contrary, they should be educated to give for the poor at all times.

And what about orphanages, homes for the aged, churches, schools and universities? Should they not tap this rich vein in the hope of striking gold? What would our communities be like if all charitable and educational institutions were to enter the business field? To develop their business activities they might even run full-page advertisements in the local papers. The go-getter advertiser might readily yield to the temptation to take full advantage of the heartbreaking plight of misery and illness as an appeal to the public to purchase his wares. What an opportunity, what a wealth of sentimental material to form the background for his display! The purchaser, on the other hand, might find an easy way of satisfying his generous impulses by buying at the neighborhood hospital apothecary shop.

The hospital's serious work demands that its trustees and executives follow a safe course and that they stay on more level ground than the seasonal and vacillating currents of commerce permit. It is especially important that the thoughts of the hospital administrator be undivided so as to allow full concentration on hospital matters.

One should not, of course, confuse this kind of side-line business with the commendable policy of some institutions which provide work, in suitable plants, for the handicapped and for people recovering from such illnesses as tuberculosis, who cannot find employment in industry and whose hours and type of work must necessarily be controlled under constant medical vigilance.



# Installing Deep Therapy Apparatus

By EARL R. CHANDLER

Superintendent, Columbia Hospital, Milwaukee

**I**N planning for the installation of a deep therapy unit in a hospital's department of radiology the superintendent and the radiologist should purchase the make of equipment that can be fitted into the space available, and should adapt the space to the apparatus, not the apparatus to the space.

An example of how this can be done is seen in the deep therapy unit recently installed at Columbia Hospital, Milwaukee.

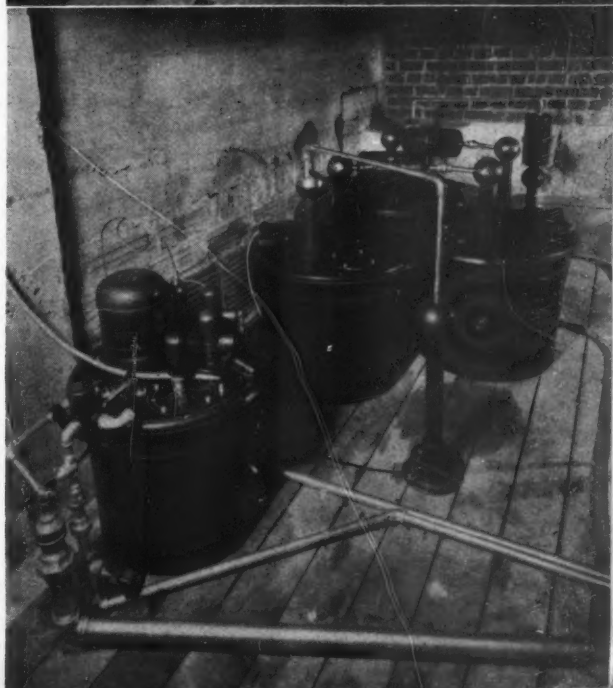
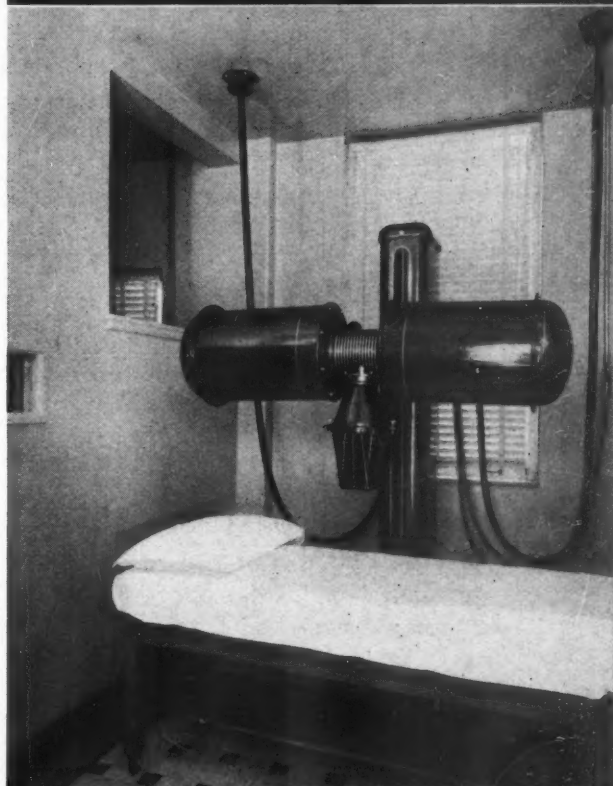
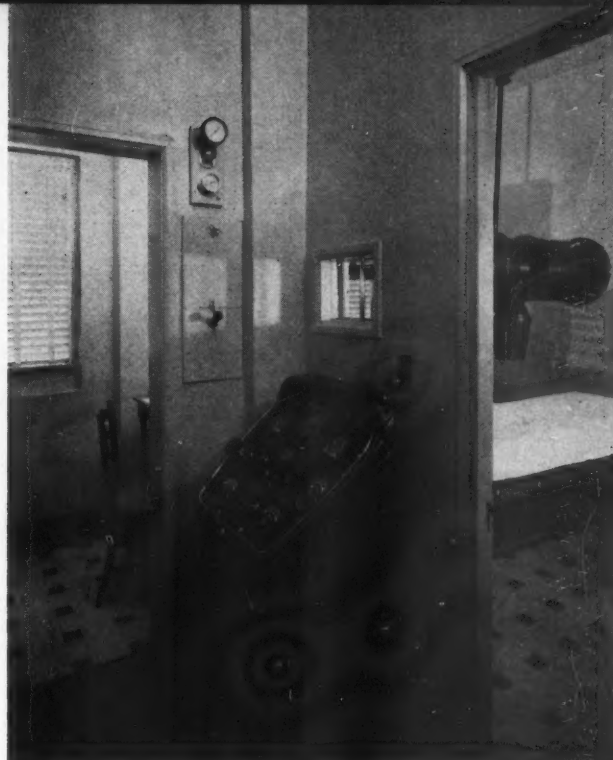
It was planned to equip the department with a 200 P.K.V.-25 MA. shockproof therapy unit. In installations of this type, it is usually necessary to provide a good sized room which is the treatment room and which contains the tube stand, a dressing room, a control room and a room for the generation machinery.

In this case, the space available was too small to permit laying out all these rooms in a utilizable size. There was, however, a double ceiling of a depth of 5 feet over the rooms that could be used as a space for the generating machinery. A make of equipment was purchased, the generating apparatus of which would fit into this space satisfactorily. The bottom picture shows the transformer, the condensers and the cooling apparatus in their space in the double ceiling. A penthouse on the roof gives easy access to this room. It is clean, warm, and dry and serves its purpose admirably. The high tension cables go from here through the ceiling into the room below, which is the treatment room, shown in the center picture.

This room is about twelve feet square and contains the shockproof tube stand and treatment couch. The high tension cables come to the tube stand from the ceiling and from it go the oil cooling lines which run up to the cooler in chromium plated pipes. The color scheme is a soft green to harmonize with the dark green of the machinery. The lighting fixtures are of modern design and are cadmium finished.

The dressing room and control room are shown at the top of the page. The floor and wall coverings are the same as those in the main treatment room. The dressing room is small, but it is well lighted and contains a chair and dressing table.

The control room contains the control stand of the unit and the technician sits here while giving the treatment. The patient can be observed through a heavy lead glass window.





*This view shows inset copper tile to ground electrostatic charges. The entire floor area is grounded through copper contacts set between all tile outside the area of copper tiling, ensuring against a static spark.*

## Protecting Patients Through Air Conditioning

By FRANCIS J. EISENMAN, M.D.

Garfield Memorial Hospital, Washington, D. C.

**E**RECTED at a cost of nearly \$70,000, the new surgical pavilion at Garfield Memorial Hospital, Washington, D. C., was planned so as to surround the patient with the utmost safeguards that hospital engineering has devised, especially in relation to the dangers of infections and explosions. It provides the environment without which the skillful work of the surgeon may be unavailing and reduces the possibility of operative mishaps to a minimum.

The pavilion was constructed after inspection of modern operative establishments in other American cities and in consultation with the fore-

most surgical, engineering and architectural authorities. It has four major operating rooms, three entirely new and one radically renovated so as to fit into the advanced pattern. In addition there are two rooms for tonsil operations and three diagnostic rooms which can be used for surgery if necessary.

The pavilion represents the realization of an ideal which has been in the minds of the hospital's board of directors for several years, as the advances in surgery have made obsolete some of the

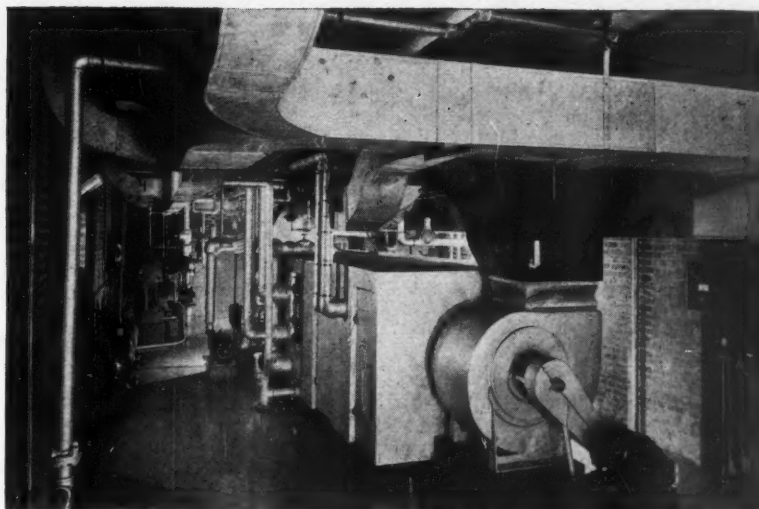


equipment which represented the latest progress a few years ago. The realization became possible through the generosity of Senator Couzens of Michigan, who, learning of the need through his own physician, provided \$22,500 towards the cost of the project.

For a century the nightmare of surgery has been infection — the invasion of an open wound by some sort of micro-organism. The surgeon's ideal has been absolute asepsis. He would, if he could, keep the micro-organisms away from the wound altogether. But bacteria are ubiquitous. The air is full of them. Ordinarily everything one touches is covered with them. The number is reduced, of course, by cleanliness and sanitation but many remain.

When the rôle of micro-organisms in wound infection first became known heroic measures were taken. Operations were performed sometimes while the operating room was filled with a weak carbolic acid spray. This was not very effective in eliminating the bacteria and acted adversely on the prompt healing of the wound. The profession gradually abandoned this and other equally striking methods of antisepsis.

It was found that better results could be obtained by ensuring, as far as possible, the absolute



*View of the air conditioning plant.*

sterility of everything that came in contact with the wound — the instruments, the dressings, the catgut, the hands of the surgeon, and of his assistant. Seemingly exaggerated cleanliness became the rule in operating rooms. The surgeon had to learn to wash his hands — to scrub them to the point where it was certain that they would be absolutely free of any contamination. Similar precautions were taken with the dressings and the instruments. The amount of infection following operation was greatly reduced. Still the asepsis was not complete. Apparently it could not be complete unless surgery was performed in a vacuum.



*In the main sterilizing room the dressings and bandages pass through the sterilizing apparatus directly into the scrubbed air and never after come in contact with any other air.*

Then came air conditioning and an apparent solution of the problem. It required a special kind of air conditioning. That used in theaters, trains and offices is for comfort — not necessarily for sanitation. Undoubtedly it decreases the number of micro-organisms in the atmosphere but it does not eliminate them. In the Garfield Memorial Hospital set-up every bit of air that enters the operating pavilion is "scrubbed" in water. It is pulled through a spray of filtered water by powerful fans and in the process practically every bit of the "dirt" is taken out of it. How vital this precaution is may be gleaned from the experience at Garfield, where after two months' operation, almost half an inch of sediment was found in the bottom of the tank. It all came from the supposedly clean air which otherwise would have surrounded the open wounds while the operations were in progress. The scrubbing of air is one of the latest and greatest advances in surgery, probably as significant as any development in surgical technique.

The air conditioning system consists of a central station type air washer plant which circulates air continuously to the operating rooms, the anesthesia room and the scrub rooms. Under normal conditions almost all the air is drawn from the outside and only a small portion of it is re-used.

Entering from the outside at a point 15 feet above the uppermost portion, all the air to be re-circulated is drawn through the air washer, which is a water spray chamber, in which the air is cleansed and cooled or warmed, depending upon the temperature of the water being sprayed, which in turn is automatically controlled by the requirements of the outside weather.

#### *Room Is Free From Drafts*

From the air washer, the air is drawn into the supply air fan which circulates it to the rooms to be conditioned. In these rooms, the air enters and leaves from air grilles located in each corner and built above the instrument and storage cabinets. The grilles are set diagonally across each corner and arranged with directing vanes that cause the air to travel round the perimeter of the room, close to the wall. This method leaves the room absolutely free from drafts, yet provides an undetectable swirling motion of the air that efficiently removes all the heat from the operating lights and from the patient and operating staff.

During 1935 Washington hospitals showed an increase of between 15 and 20 per cent over 1934 in the number of surgical cases admitted. For the same period the increase at Garfield Hospital was actually 35 per cent. I attribute this to the fact that Garfield Hospital offered the members of

the public more comfortable operating facilities.

Great has been the advance in a generation. Hardly two decades ago a small amount of infection of every wound was considered unavoidable. The progress of this infection was one of the guides of the physician. From the nature of the reaction he could tell how successfully the blood stream was resisting the invasion. It is all different now. If the surgeon sees the slightest sign of bacterial invasion, even around the catgut threads used to close the wound, he grumbles at the poor sterilization and demands an investigation.

The entire operating pavilion — operating rooms, diagnostic rooms, nurses' rooms, doctors' rooms, supply rooms, instrument closets — is pervaded by this scrubbed air. The dressings and bandages pass through the sterilizing apparatus directly into the scrubbed air and never afterwards come in contact with any other air. The gowns and gloves of the surgeon, the instruments, the table, never are in contact with any other atmosphere.

#### *Precautions Against Explosions*

The nightmare of infection dates from the beginning of surgery. Another operating room hazard is of more recent origin. It is explosion. Now and then an account of an operating room explosion appears in the papers and the public is indignant that there could be such carelessness. Those familiar with the situation, however, know that explosions have happened in spite of great care. Such care was not necessary a decade or more ago when almost all major operations were performed under ether. Ether, of course, is explosive under certain conditions, and always it has been necessary to avoid the use of open flames near the scene of the operation. It has been the introduction of other anesthetic gases and the use of oxygen in combination with them or in combination with ether that has increased the explosion hazard and has made extraordinary precautions necessary. Such precautions are taken whenever these anesthetics are used, but the extra care required is compensated for by the extra safety and comfort provided the patient by the use of better anesthetics. One of the interesting features of the new operating rooms at Garfield has been the introduction of an ultimate precaution against gas explosions. The floors have been filled with metal tiles and coils so arranged that as the members of the operating team move about they are constantly "grounded." The risk of setting off a spark from shuffling the feet over the floor is eliminated. A relative humidity of not less than 55 per cent is necessary in order to ensure against a static spark.



# What Is Expected of the Personnel in Case of Fire

By V. L. DOUTHIT  
Fire Protection Engineer, Chicago

**W**OULD one of your nurses, under the stress and excitement of a hospital fire, pick up a fire extinguisher and fling it bodily into the flames? During a fire in a manufacturing plant in the Middle West not long ago, the plant superintendent did just that.

Now this plant superintendent is not a person of low intelligence; he is an outstanding man in his field. He simply did not stop to think what he was doing, and he had never developed a definite plan to follow in the event of fire. He unconsciously associated the extinguisher with fire and immediately applied the one to the other, but in a hopelessly ineffectual manner.

## *Fundamental Safeguards Essential*

The problem of organizing and training hospital personnel in the duties of quenching incipient fires and of removing patients to places of safety during a fire is one of the most difficult in fire prevention procedure. Too much cannot be said in favor of the use of the best fireproof construction in the erection of hospitals and of adequate fireproof fire exits for removing helpless patients to places of safety. Every hospital should have its supply of first aid fire fighting equipment for combating fires before the fire department arrives. The importance of good housekeeping — safeguarding hazardous devices, commodities or processes and ridding attics and other seldom visited areas of accumulations of rubbish and waste — cannot be overemphasized. Insistence upon these physical safeguards against fire forms the basis of fire protection.

These are physical safeguards involving material things. Anyone with the will to provide them and the materials and labor or financial responsibility to carry them out may readily build a modern, well equipped, fireproof hospital. Fires, however, frequently are caused by the personal element and their extinguishment is dependent on persons. In the development of a personnel trained to cope with the condition of excitement or panic accompanying even the smaller fires, we are dealing with individuals, and the problem is for that reason considerably more difficult, in

much the same manner as a mental case may be more difficult than a simple fracture. We know, too, that hospital staffs — nurses, interns and doctors — are above the average in coping with unusual situations, but even resourcefulness will not compensate for lack of knowledge.

To lay down specific rules to be followed in all hospitals is obviously impracticable. Nevertheless, well defined general principles apply to general hospitals, sanitariums, and corrective institutions, and it is with these that we shall be concerned. We shall exclude from this discussion those institutions housing patients most of whom are able to walk, for in them an entirely different type of fire drill should be used.

Fire and exit drills as ordinarily practiced in schools or factories cannot be conducted in hospitals. Fundamentally, superior construction, early discovery of incipient fires, prompt alarm and first aid fire appliances must be relied upon to reduce to a minimum the occasion for evacuation of such buildings. The hospital fire drill, therefore, usually will include schooling employees in: (1) extinguishing fire; (2) directing walking patients and (3) attending and moving bed patients.

That persons tend through repetition of procedure to react in a definite way when a particular stimulus is applied, is the theory underlying the fire drill. Consequently, although it is frequently difficult to hold regularly practiced drills in hospitals, because of the alarm and annoyance to patients, that practice should be followed whenever possible. Since regularly practiced drills are so often impracticable, the need for constant and regular attention toward preparedness in fire prevention and protection is immeasurably increased.

## *Fire Marshal in Charge of Drills*

All fire drills and other such training of personnel should be in charge of the marshal or institution fire chief. This individual preferably should be an experienced fireman, having qualities demanding respect and attention and capable of discharging his duties with intelligence. The importance of this position should not be underestimated, particularly in buildings of more com-

bustible construction. An ardent and conscientious fire fighter, receiving the cooperation of the staff in his work, adds materially to the safety of the occupants. In those hospitals in which an experienced fireman cannot be employed to act as fire marshal, this position should be filled by a member of the staff in authority, and he should devote a definite portion of his time to the conduct of that office.

The duties of the fire marshal are numerous. He should be responsible for the location and sufficiency of first aid fire-fighting apparatus, its repair and maintenance. He should instruct the personnel, including the staff, in its use by actual handling of extinguishers and other such equipment. The fire marshal should instruct and direct all employees in the purpose and use of the fire alarm system, fire drill and response to alarms, in order not to interfere with essential hospital routine. He should inspect regularly attics, basements, wards, closets and storage spaces with authority to eliminate unnecessary and hazardous conditions; supervise the repairs to fire doors, exit doors, ramps, stairs and other means of egress, and, with the cooperation of the engineer, check and maintain adequate water supply to sprinkler systems and standpipe and hose systems.

Another important duty of the fire marshal is the development and maintenance of a friendly contact with the local fire inspection or underwriting board and the local fire department chief, in order that he may have available complete information and the cooperation of those organizations and individuals in successfully carrying on his work. Many excellent ideas may be secured through these agencies.

#### *Procedure in Case of Fire*

Having analyzed your particular hospital conditions, secured sound advice on fire preventive and combative training of personnel, and organized your hospital staff and auxiliary employees for that purpose, how will the plan work under the stress of an actual fire?

The person discovering the fire should with the least disturbance and commotion possible immediately send an alarm from the nearest fire alarm box and see that all doors adjacent to the fire are closed. He should then inform another employee of the location of the fire, the latter confirming the original alarm to the main office and then joining the discoverer at the fire. The discoverer should immediately upon informing the other employee return to the scene of the fire and attempt to extinguish it with the first aid appliances available.

Those who respond first to the alarm, together

with those who discovered the fire, assume the duties of the fire brigade and constitute the first defense against fire. They should strive to extinguish the blaze with the least confusion and annoyance to adjacent sections. Their instructions should be "Keep your head and do not quit, even though unsuccessful, but endeavor to check the spread of the fire until the arrival of the fire department." One of these first individuals to respond to the alarm should be sent to direct the firemen to the scene of the fire.

#### *Monitors Assume Responsibility*

The next arrivals, other than those actually engaged in fighting the fire and working simultaneously with them, constitute the monitors for the time being. They should open horizontal exit doors to adjacent sections away from the fire and conduct ambulant patients immediately to those sections. Certain of these monitors should remain with their charges, in readiness to conduct them still farther from the source of danger should that be necessary. Those monitors not required for that purpose should return to check on delinquents and to serve as guards near the fire.

Other arrivals at the fire are guards whose duty it should be to reassure and quiet the patients in the immediate zone of the fire or smoke, and to proceed to move the beds of the more seriously excitable to points from which they may be readily moved should it be necessary to evacuate the section or building. By this time assistance of monitors should be available and an adequate force must stand guard for this emergency.

If the fire is still uncontrolled or has developed a bad smoke hazard, all available guards, monitors and firemen should move patients out of the sections involved by rolling or sliding their beds or mattresses through horizontal exits or down ramps when these are available. As a last resort, if required by continued spread of fire and smoke into the section being vacated, they should carry patients in mattresses down stair towers.

It is suggested that in analyzing your hospital and planning the training of your staff along the lines of fire prevention and life protection, as well as other methods of fire protection, you consult your local fire rating and underwriting organization. If it does not have an engineer available for this type of service, it will be able to secure one for you. No charge is made for this advice.

It may be stated again that reasonable safety to life in hospital buildings requires: (1) proper construction of buildings; (2) adequate exits; (3) careful housekeeping and protection of fire hazards, and (4) a competent trained staff with adequate personnel on duty at all times.



# Sales Tax Legislation and Hospitals

**T**WENTY-FOUR states found it necessary to levy sales taxes on retail purchases for the purpose of increasing revenues to meet the current emergency and have such taxes in effect as of February 1, 1936. In seven of the twenty-four the tax does not apply to nonprofit hospitals, which are exempted with other charitable institutions, although private hospitals organized for profit fall into the business enterprise class.

In the seventeen states where the tax applies to sales to or by nonprofit hospitals, regulations fall largely into a few general groups. In Iowa, Illinois, New Mexico and Missouri, hospitals must pay the tax to the vendor on all purchases. In New Mexico and Missouri the hospitals have no further responsibility, but in Iowa and Illinois they must collect the tax on sales in public dining rooms, pharmaceutical dispensaries or on sales apart from the rendering of hospital service.

North Dakota hospitals pay the tax on all purchases "to be consumed in hospital service." Where the hospital makes special charges for goods sold through a pharmaceutical dispensary or otherwise apart from hospital service, it must, like the states just mentioned, collect and remit the tax.

Hospitals in California, New York, South Dakota, Utah and Wyoming are considered consumers and as such must pay the consumers' tax at the time of purchase on all goods whose charges are not to be relegated to patients, except that the California bill exempts food purchases from taxation. In all of these states except Utah, the general rule is made that the hospital may collect the tax from the patient on any separately billed charge for meals, medicines, bandages, drugs. In these cases the patient is the consumer. Utah hospitals must give the vendor a resale certificate on these special goods guaranteeing that they will collect the tax from their patients and remit it, if they wish to relegate tax charges.

Ohio has made an arbitrary separation of hospital purchases into two classes. Of one group, which includes equipment and nonconsumable supplies and maintenance supplies, the hospital is the consumer. It must pay the tax to the vendor on any purchase of such goods. Drugs, chemicals, professional supplies (including bandages, splints, x-ray films and other similar materials), anesthetics and food are considered "sales for the pur-

pose of resales," and the tax does not apply to such purchases.

Arizona hospitals are exempt from the sales tax, but their patients must pay the tax on all medicines purchased as prescriptions. Colorado hospitals are also exempt.

Retailers in Michigan pay a tax on all sales, which they may or may not collect from the consumer, as they see fit. The hospital is considered the consumer and is therefore liable for the tax. Hospital patients in this state are by the same ruling liable for tax on purchases of "tangible property" for which they may be billed by the hospital when the hospital has not already paid the tax. Services are not assessable.

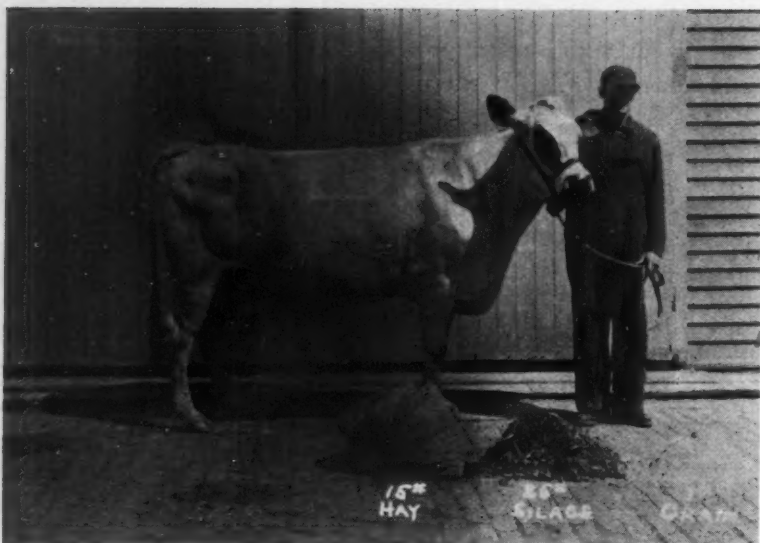
Mississippi requires the jobber to pay a tax of one-eighth of 1 per cent and the retailer a 2 per cent tax, which they also may or may not collect

	Rate of Tax (Percent)	Hospital Liable	Patient Liable
Arizona.....	.	No	Yes
Arkansas.....	2	No	No
California.....	3	Yes	Yes
Colorado.....	.	No	Yes
Idaho.....	2	No	No
Illinois.....	3	Yes	No
Indiana.....	1	No	No
Iowa.....	2	Yes	No
Maryland.....	1	No	No
Michigan.....	3	Yes	Yes
Mississippi.....	2	Yes	No
Missouri.....	1	Yes	No
New Mexico.....	2	Yes	No
New York.....	1	Yes	Yes
North Carolina...	3	Yes	No
North Dakota...	2	Yes	No
Ohio.....	3	Yes	Yes
Oklahoma.....	1	No	No
Pennsylvania....	.	No	No
South Dakota....	2	Yes	Yes
Utah.....	2	Yes	Yes
Washington.....	0.05	No	No
West Virginia....	2	Yes	No
Wyoming.....	2	Yes	Yes

from the consumer. Here, too, the hospital is considered the consumer and may be liable; the patient is never liable.

All sales in North Carolina are taxed likewise — the wholesaler paying 0.5 per cent, the retailer 3 per cent. The retailer in this state passes his tax on to the consumer, however, and the hospital therefore pays 3 per cent on all retail purchases. Hospital purchases at wholesale are exempt, as are all sales by the hospital.

West Virginia has both sales tax and gross income tax.



*Daily ration of a dry cow.*

## Mental Therapy Through a Dairy Farm

**C**ULTIVATION of the soil with its allied activities furnishes occupation and recreation of the most healthful character. Probably no hobby is more universal among all peoples of the earth than some phase of farming.

Farming is usually thought of as work, and its recreational possibilities forgotten, but when I allude to the occupational value of any phase of farming an equal recreational value is always implied.

During the World War a professional group calling themselves occupational therapists began to gain recognition. Psychiatric hospitals having long recognized the value of work therapy welcomed members of this new group. They added to the old work therapy program a few basic principles and ideals, first, the application of scientific educational methods; second, the principle of progressive education; third, an intelligent search for employment interesting to the particular patient; fourth, personal professional attention to the balancing of employment and recreation for each patient; fifth, diligent search for reeducational procedures tending to aid in a new community adjustment.

### *Benefits of Farming Activities*

A psychiatric hospital, maintained by tax money and serving a public earning only a marginal existence, cannot hope to have floor space, equipment and materials sufficient to furnish arts and crafts occupation for the hundreds of patients needing an outlet for their interests and energies. Shop work and production methods are undesirable in that they produce materials which must be sold in competition with private industry and bring the temptation to put large production be-

fore healing and soothing occupation. Therefore, the ideal of such a hospital should be to become as nearly self-sustaining as possible through the application to its own uses of all needed arts and trades, thus furnishing the widest range of occupational interests for its patients.

Farming activities provide the most diversified recreation-occupation possibilities of any industry. An intelligent and well trained occupational therapist can find on the farm a wealth of treatment opportunities. The coordination of the occupational therapy department and the farm management may call for tact and much educational effort, but success is well repaid by the obviously increased mental contentment and physical well-being of the mentally ill.

A dairy is the heart of a diversified farming program. It provides the greatest single dietary value which can be produced from the land of the average institution. With good management a farm can develop within a few years a herd free from tuberculosis and Bang's disease, with the animals of any desired breed and of a quality eligible for registration.

The control of bovine tuberculosis is based upon tuberculin tests that point out the disease in its earliest stages. The immediate slaughter of animals showing positive or suspicious reactions quickly eradicates herd contagion. Fresh air, sunshine, adequate diet and exercise are important in raising tuberculosis resisting animals.

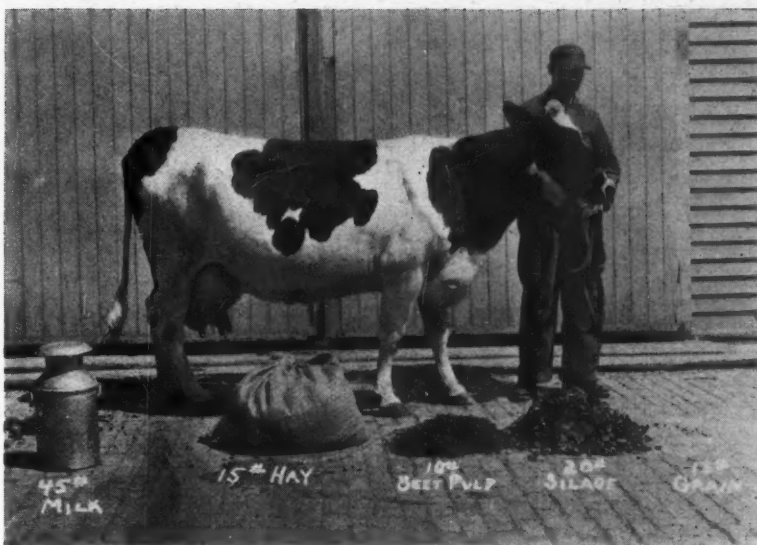
In the barns attention should be given to the circulation of a sufficient amount of clean air without causing direct drafts or rapid and excessive changes of temperature. Much exercise out of doors is essential during the growth period. Pasturage during the summer months and free access



# The story of a hospital farm in the state of Pennsylvania

By IRA A. DARLING, M.D.

Formerly Superintendent,  
Warren State Hospital, Warren, Pa.



Daily ration and production of milch cow.

to exercise yards in the winter aid in building up healthy bodies with maximum resistance to disease and great potentiality for future large milk production. Throughout the lactation period a daily run of at least two hours in exercise yards or pastures helps to maintain health. While cows are dry, it is wise to revert to the exercise routine used for growing stock.

Warren State Hospital, Warren, Pa., has inadequate acreage and poor land for pasture. This makes it necessary to feed young stock and dry cows generous supplementary rations during pasturage periods. Under existing conditions this extra dietary requirement has been found by experiment to be from six to eight pounds of grain mixture daily. Poor pasture facilities also make it necessary to bring green feed to the producing cows even though they have short periods of grazing in the pastures.

## Record Is Kept of Milk Production

We have found it satisfactory to hand raise calves after the first three to five days, feeding them surplus skim milk and a commercial calf meal. The milch cows are fed one pound of grain mixture for each three and a half pounds of milk produced. An exact record is made of each cow's milk production and the grain mixture prescription is changed every week on the basis of this milk record. We have found it more economical to purchase the ingredients and make our own grain mixtures; this permits buying carload lots of standard materials on a competitive basis.

The general dietetic rule followed calls for a ration of 18 parts crude protein, 4 parts fat, 66 parts carbohydrate and 12 parts fiber for milch cows. If alfalfa is available, 16 per cent protein

is given in the grain ration; with mixed hay the protein is increased to 18 per cent and with poor roughage to 20 per cent. Heifers and dry cows are given only 12 per cent protein. Roughage is given milch cows as many times a day as the cows are milked and each animal is allowed all that she desires.

Grain ration formulas must be varied according to other feed being used. The following is one of the standard formulas used on the Warren State Hospital farm:

	Percentage
400 lbs. Yellow corn, U. S. No. 2...	
400 lbs. Oats, U. S. No. 2, white...	
400 lbs. Fine cut alfalfa hay.....	
200 lbs. Standard middlings.....	Protein (crude)...18.55
200 lbs. Pure wheat bran.....	Digestible carbohydrate.....47.
100 lbs. O. P. linseed meal.....	Fat.....4.66
100 lbs. Cottonseed meal, choice...	Fiber......12
100 lbs. Soy bean meal.....	
20 lbs. Iodized salt.....	

For young stock and dry cows the following is a standard formula:

	Percentage
100 lbs. Yellow corn, U. S. No. 2...	
100 lbs. Oats, U. S. No. 2, white...	Protein (crude)...16.
100 lbs. Pure wheat bran.....	Digestible carbohydrate.....50.
75 lbs. O. P. linseed meal.....	Fat.....5.17
	Fiber.....8.

It is a wonderful experience to have had a fine dairy herd badly infected with Bang's disease, to have eradicated the infection and to have built up a new herd without the purchase of a single cow. Our fight covered a period of ten years. Always there was low milk production both for the herd and for the individual cows. Some years comparatively low feed costs with relatively high milk process permitted small profits, more often there were deficits.

Final success was due to following carefully a program prescribed by the Pennsylvania bureau

of animal industry. An agglutination test was made for each animal every three months. Every animal reported as "suspicious" or "positive" was placed in strict quarantine away from "negative" animals. The occasional full term calves of these presumably infected dams were removed immediately from contact with them. Every healthy female from these dams was raised as a potential replacement for the herd.

These calves were tested for blood agglutination by the time they were six months old and at regular intervals with the entire herd thereafter. "Negative" cows were placed in individual pens of a special maternity barn two weeks before freshening. Two weeks after freshening another blood specimen was obtained and the cow held in this stall until an agglutination report was available. A negative report at this time sent her back to the healthy herd; a positive sent her to the quarantine station.

#### *The Breeding Program*

Throughout the ten-year period no female was brought in from other herds so that no outside infection was introduced. By 1927 enough young healthy heifers were available to permit the immediate slaughter of all animals with positive reactions. The frequency of abortion and the few healthy calves available made selective breeding and culling impossible throughout this period. Some selective breeding was possible in 1928 and by 1930 the program to build up production was in full swing.

We continue to make agglutination tests every six months and to carry on with the maternity barn routine including an agglutination test after freshening. We hope that these precautions will prevent the further contamination of the herd which has now had certificates of freedom from the disease for three years.

The present breeding program is based on the records of the Warren County Cow Testing Association. Every cow in the herd has an exact record of production throughout life. Replacements for the herd are selected from dams with a record of at least four hundred pounds of butterfat in three hundred and five days. Neither in-breeding nor line-breeding is practiced. New bulls are purchased from dams with records of at least one thousand pounds of butter in three hundred and sixty-five days. We hope that we shall soon be able to secure proved bulls with a high index for butterfat and milk as such animals appear to promise greater certainty of good results.

It is obvious that the more dairy food a dairy farm produces the better chance it has for profit. There is always a struggle to limit the expendi-

ture of cash from maintenance funds. Warren State Hospital is not located in a good farming region and there is little chance of increasing the present tillable acreage. The best we can hope to produce is the major portion of roughage needs. Therefore, we must plan on buying about 55 per cent (by value) of dairy food.

After attaining the goals of freedom from tuberculosis and Bang's disease, 12,000 pounds of milk per cow yearly, a bacteria count below 20,000, and a production cost below the average of the local cow testing association, a more important factor appears, namely, occupational treatment. For this purpose, one cannot consider the dairy as meaning only milch cows, rather it must be extended to include all the animals required for building up and improving its quality. It is also impossible to think of the dairy without considering the land necessary for its maintenance. One cannot exist without the other. The fertility and productivity of the land depend to a large degree upon the fertilizing value of the animals, and they in turn must have food grown from the soil.

With this idea in mind, let us consider an average hospital for the mentally ill with 2,000 patients, 400 employees and 800 acres of tillable soil. With an average production of 12,000 pounds of milk per animal, these 2,000 patients would require a herd of 125 producing cows. In order to achieve this result it is essential to figure that twenty-five animals will be constantly dry, that about thirty heifers will have to be kept for replacement purposes, and that five or six herd sires of varying ages and heredity should be available. Provision for the temporary care of from thirty to forty calves must be made.

#### *One Patient for Six Animals*

This is a total of about two hundred animals which can be used for their occupational value as well as for their milk production. If we consider only their care while in the barns, it should be possible to use with benefit one patient for each six animals. Therefore our theoretical herd should furnish healthful employment for thirty-three patients.

The types of work available in this one service vary greatly. We find such simple tasks as carrying materials from one place to another under direct supervision, picking up rubbish about the buildings, cleaning stalls, scrubbing floors and walls, keeping supplies in an orderly state, brushing and washing the cattle, also many other related tasks, some simple and some complex. A more capable group, under constant supervision, may be intrusted with the cleanliness of utensils and with the milking of cows. This detail indi-



cates the wide scattering of possibilities for many degrees of physical and mental capacity which may be found in what first appears to be a simple form of employment.

In our illustrative set-up we have 800 acres of soil on which to maintain our herd. A general farming project of this nature should furnish employment for at least one patient for every nine acres, thus supplying occupation for 111 patients. Under such conditions the herd and its maintaining land gives, without expenditure for special materials or buildings, occupational treatment facilities for a minimum of 144 patients.

#### *Many Different Jobs for Patients*

The story cannot end here because any farming as extensive as this requires much assistance from allied industries. For example, patients may be employed in the keeping of records; assisting the blacksmith in the manufacture and repair of equipment; caring for the horses necessary to operate the farm; assisting carpenters in the repair of farm buildings and equipment and aiding painters in protecting the buildings from the elements. In the conventional occupational therapy department containers may be repaired; baskets may be made for the gathering of harvests; new handles may be constructed for tools; brushes used in cleaning the barns and animals may be manufactured; boxes may be made for the storage of root crops. It is therefore apparent that the dairy, the land required to maintain it and the industries it indirectly supports, furnish a vast selection of interesting occupations which at first appear entirely unrelated to dairying.

By the proper planning of needed work far in advance, by paying particular attention to such details as the neatness of farm buildings and surrounding land, the cleaning of hedgerows and wood lots, and the repair and construction of farm roads, the peaks and valleys of employment numbers can be flattened, the farm land materially improved and equipment kept in firstclass order.

A standard adopted by Pennsylvania calls for the employment in farm activities of 20 per cent of the male patients physically capable of work therapy. A further guide generally accepted provides for the employment of one patient for each four milking cows or six other dairy animals; one for each six horses; one for each fifty head of swine; one for each 200 laying hens; one for each three quarters acre of truck garden; one for each nine acres of general farm crops. If this guide is used and a system devised whereby patients are in charge of employees trained to occupational therapy, and adequate provision is made for

changing the type of work according to the improvement or regression of the patient, routine employment activities take on an entirely new aspect and become thoroughly therapeutic in character.

The benefits of such a program should not be limited to men for sections of the farm and garden give just as natural recreation employment to women. Flower and vegetable gardens, small fruit crops, shrubbery, lawns and the hennerly have long been the pride and perquisites of farm women. Hospitalized women eagerly seek the privilege of sharing in such enterprises, with great benefit to their mental and physical welfare.

An obvious benefit of a dairy farm to a mental hospital is a constant supply of milk of known quality and freshness at a cost as low as that of any efficient producer in the section in which the hospital is located. It is an important factor in hospital costs if the herd is largely supported by the products of its farm. Under such circumstances, money need be spent only for wages, machinery and incidental supplies, the costs of which vary little from year to year. This makes possible a plentiful supply of milk with little danger of high prices making large inroads upon maintenance appropriations.

The opportunity for recreation and occupation afforded hundreds of men and women is the most important contribution of a dairy farm to a mental hospital. It is only a fortunate coincidence that good management makes possible this valuable aid to treatment and pleasure with associated dietary and financial benefits, no decrease of farm efficiency and no expenditure of money in excess of the usual requirements of farm and nursing departments.

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#### Therapeutic Control of Radium

Hospital administrators in the past have been alert to the control of radium regarding protection against its loss. It now seems that the use of this therapeutic agent should be controlled as to therapy just as much as are the operating room, x-ray department and other like divisions of the hospital. One hospital recently adopted the following procedure concerning radium therapy. The physician desiring to use radium has a consultation with the chief of the service. The chief, after considering the pathologist's report, writes his consultation with recommendations as to dosage and filtration on the patient's chart. The radiologist is then requested to write his consultation on the chart with recommendation as to the radium application and x-ray therapy. Following this the radium is issued to the physician for its application. It seems that this type of control is not only desirable, but essential for the sake of rational treatment of malignancies. — *Lewis E. Jarrett, M.D., Hospital Division, Medical College of Virginia, Richmond, Va.*

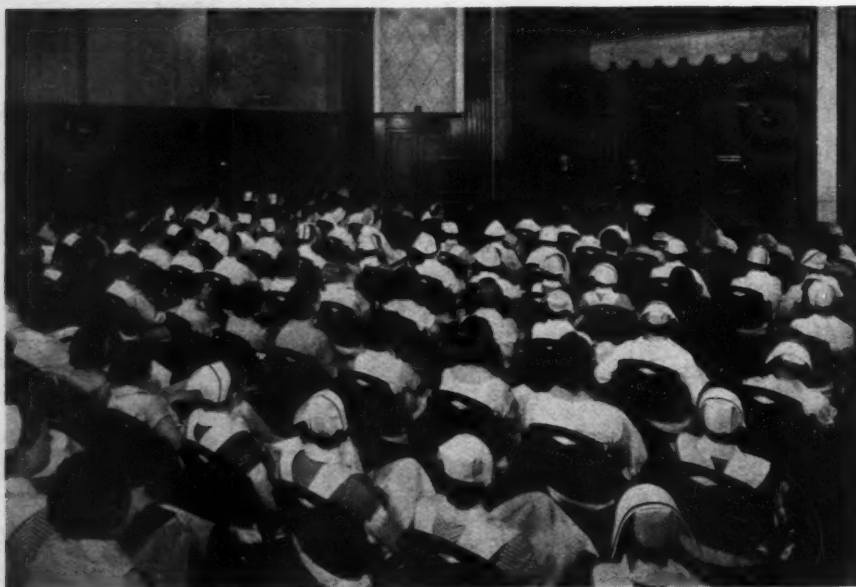
# What Others Are Doing

## *Controlling Fire at Children's Memorial*

There is no panic, no uncertainty, when fire is discovered at the Children's Memorial Hospital, Chicago. A systematic course of instruction for nurses, employees and staff members has eliminated all elements of terror

guishers are refilled before the expiration of each year.

"We have had several minor disasters," writes Mabel Binner, superintendent. "It seems utterly impossible to control the situation 100 per cent. Thus far nothing serious has ever occurred. In no case has the damage ever exceeded the sum of \$50."



from this much dreaded source.

Six times a year, when new students are admitted to the nursing school, a demonstration in the use of fire extinguishers is given by the principal of the school of nursing. These demonstrations are attended by an employee who may have been hired since the previous demonstration. Minutely detailed regulations, "What to Do in Case of Fire," are posted on wards, in offices and in other locations. Interns, nurses and others particularly concerned with the care of patients in case of fire are given copies.

Once every two years the entire hospital personnel assembles for an address by Captain Rogers of the Western Actuarial Bureau and a review of the question of fire prevention. Fire drills as such have been abolished by the institution as not feasible in a hospital. Fire hazards are checked carefully; no smoking signs are posted in all parts of the building, and oxygen tents are labeled "Caution, No Flames Where Oxygen Is Being Used." Fire extinguishers are checked annually, and the soda-acid extin-

## *Utilizing Isolation for Publicity Purposes*

It is noon in Montana. On isolated farms and ranches throughout the state people are tuning their radios. A program comes to an end and the voice of an announcer is heard in homes that the mailman reaches but twice a week and telephone lines never. "You are listening to station KFBB, Great Falls. The time is now 11:55 and it is our pleasure to bring you the daily broadcast from the Montana Deaconess Hospital."

Back in Great Falls, hundreds of miles from some of its listeners, the hospital begins its broadcast, by remote control, from the institution itself. One minute is devoted to an educational editorial on hospitals, and

then comes four minutes of news for those isolated ones about the patients they know in the hospital. That Bob Jones of the Bar Z is resting comfortably following his admission last night; that Nancy Lee, teacher at Kitchen's Corners, has passed the crisis and is recovering nicely; that Jim Allen will be discharged the next day.

This rural program is but part of the institution's publicity program on the radio. On Friday evenings the hospital broadcasts a fifteen-minute educational program with talks by doctors, hospital workers and service organizations. Some of the talks given on the series have been "Cancer Is Curable," "Care in Communicable Diseases," "Hospitals Old and New," "First Aid to the Injured," and "Preparation for Nurse Training." The address is from eight to ten minutes long and the program opens and closes with music.

"I have never known in any community programs that have met with such universal approval as these have," writes Blanche M. Fuller, superintendent of the hospital. "All our educational talks are as applicable to other hospitals as to our own. We are not in any way using these programs to advertise the hospital except indirectly as we sponsor it and report at the noon hour on the patients in our own hospital. I have yet to hear one word of criticism from either hospitals or doctors."

## *Educating Expectant Mothers at St. Vincent's*

Introducing the young expectant mother to the hygiene of pregnancy and the care of the baby through a series of social gatherings is now being tried at St. Vincent's Hospital, New York City, by the prenatal clinic. Each Wednesday afternoon a group of these women meet at the hospital, listen to talks by members of the obstetric and pediatric staffs, study exhibits composed of the proper clothing for themselves and the baby and of the necessary articles used in caring for the baby, and gossip with each other over the tea served by the hospital. At the end of the series of meetings, each woman who has attended regularly will be given a diploma at graduation exercises held by the clinic.

*Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals*



# What Two Years' Trial Proves About the Flat Rate Plan

**W**INDHAM COMMUNITY MEMORIAL HOSPITAL, Willimantic, Conn., is a general hospital of ninety beds, serving a city with a population of 13,000 as well as sixteen adjoining rural communities with a total population of 32,000. It has just completed two years' experience with a flat rate plan in its maternity department.

The hospital is now in its third year in its new buildings after serving the community for twenty-five years in remodeled buildings which were not adapted to modern maternity work.

When the new hospital was opened, the previous years of service in the surgical, medical and accident departments fully explained the increased service in these respective sections. The maternity department, however, assigned a separate floor in the new building with a complete suite of utility, sterilizing, labor, delivery, and

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nursery rooms, was not occupied in the ratio that was anticipated, due mainly to the fact that in all the previous years maternity hospitalization was not available.

After the first year, the present flat rate, or, as generally known, middle rate plan was evolved and proved acceptable to the trustees and the professional staff. This rate, governing maternity cases, includes the services of the family physician and all hospital expenses for the sum of \$65. Of this the physician receives \$25 and the hospital \$40. During the first year of its operation, the rate was \$5 less. The service includes private



*The solariums which are at the end of each corridor are comfortably furnished and gay with flowers and plants. Convalescent patients find them cheerful spots in which to lounge or read.*

ward bed (four beds to a ward), use of labor and delivery rooms, bassinet, nursery and identification service (\$1 extra if bracelet is retained). Patients must be admitted through the family physician who should be a member of the staff in order to benefit under this rate. Thirty dollars is payable upon admission and the balance on or before leaving the hospital.

The hospital authorities feel it advisable to

TABLE I—COMPARISON OF DEPARTMENT PRIOR TO AND AFTER FLAT RATE WAS INSTITUTED

Year 1933—No middle rate plan.....	76 births
Year 1934—With the middle rate plan.....	173 births
Year 1935—With the middle rate plan.....	199 births
Average stay prior to flat rate.....	10.6 days
Average stay flat rate first year.....	11.2 days
Average stay flat rate second year.....	11.3 days

maintain the \$65 rate, which is exceedingly low, due to the economic conditions in this textile area, and to the fact that two years of experience show that with as few as 13 per cent of the cases in private rooms and with 11 per cent ward or free work, plus a good collection service the entire costs of this department are fully covered.

The analysis of the two years' experience proves conclusively that the hospital is the best place to be born. The ratio of deaths is much decreased notwithstanding the fact that in this two years' experiment every case that applied was admitted. Of the total number of births, 372, in this period, only three infant deaths, eight prematures and fifteen stillbirths are recorded and there was not a single maternal death since the hospital opened in 1933.

Certain members of the staff argued that the middle rate plan would preclude the possibility of maternity practice in the private rooms because in this institution the maternity wards are small and modern. Analysis does not prove this assertion. During the first year 64 per cent of the hospital cases used the middle rate plan, 30 per cent used the private rooms, and 6 per cent were indigent or free cases. This first year 13

TABLE II—MATERNITY DEPARTMENT CASH STATEMENT, 1935

	Cash Received	Accounts Receivable	
Private cases.....	\$ 1,973.27		\$ 1,973.27
Flat rate.....	9,177.70	\$175.00 <sup>1</sup>	9,352.70 <sup>2</sup>
Town and free.....	725.39	10.85	736.24
Ward.....	205.60	128.35	333.95
	\$12,081.96	\$314.20	\$12,396.16

<sup>1</sup>Includes three in hospital last day of year. Payment not due until discharge.

<sup>2</sup>Of this amount \$3,601.38 has been paid the doctors, and \$123.62 is still due them.

per cent were private, 76 per cent flat rate and 11 per cent town or free cases.

The cost per patient day last year for all departments was \$5.37, and there was a total of 2,251 maternity patient days. The gross cost for the maternity department figured \$12,087.87, and the actual cash receipts \$12,081.96. The gross income from this department was \$12,489.89. Cash collections from private room cases were 100 per cent, from middle rate cases 98.1 per cent, while general ward cases were found to average 87 per cent.

In summing up the flat rate plan for the past year, out of 149 cases (one was carried over from 1934), 138 paid in full while in the hospital, ten were partly paid at the end of the year and only one case was a bad debt.

Eleven doctors of the staff use this plan and a great deal of enthusiasm has been developed. In this short period of time, the general apathy of the public toward the use of hospital facilities for maternity cases has in great measure been overcome. (Table I.)

It might be thought that the flat rate cases

TABLE III—COMPARISON OF SERVICE AND INCOME OF VARIOUS TYPES OF MATERNITY PATIENTS, 1935

	Private	Flat Rate	Town and Free	Ward	Total
Number of cases.....	25	149	18	4	196
Percentage.....	13	76	9	2	100
Fully paid.....	25	138	14	2	179
Partly paid <sup>1</sup> .....	0	9	0	2	11
Unpaid.....	0	1	2	0	3
Bad debt.....	0	1	0	0	1
Free.....	0	0	2	0	2
Patient days.....	300	1,701	193	57	2,251
Average stay (days)....	12	11.3	10.6	14.2	11.4
Gross hospital income per case (exclusive of physicians' fees)	\$78.93	\$37.77	\$40.90	\$83.49	

<sup>1</sup>In hospital last day of year.

would stay longer than the private cases since it would not add to their costs. No rule has been made on this point except to state to the staff that rates are based on normal cases averaging eleven days' stay. The excellence of their cooperation is shown in Table III.

Follow-up service is rendered to all cases upon discharge and the hospital officials through a series of printed cards keep in contact from time to time with the family. A special birthday card is sent to every hospital-born baby upon the occasion of its first birthday.

On National Hospital Day each year, the mothers and babies are entertained at the hospital with the enthusiastic assistance of the members of the junior auxiliary.



# Checking Linen and Cotton Goods

By GEORGE H. JOHNSON

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ONE of the major problems which any hospital buyer must solve if he is to purchase linens and cotton goods with maximum efficiency is that of shrinkage—rather, of making sure that the materials which he purchases will not shrink unduly when they are laundered. This is especially important in purchasing garments that are tailored to fit.

To understand this problem of shrinkage, and know how to avoid it in buying, one must understand something of the causes of shrinkage. Of course, in days gone by, it was common practice to place full blame for the shrinkage of cotton upon the laundry or the laundering methods. However, enlightened modern thinking, based upon accurate scientific research, has proved the fallacy of this reasoning, and has likewise proved unsound the line of reasoning that "You may as well expect it to shrink—you can't buy materials that won't shrink when they are washed, anyway." Scientific study by textile and laundry interests—notably, the American Institute of Laundering—has disproved the former idea, and modern scientific methods of careful preshrinking

*The author urges the buyer of cotton and linen fabrics (1) to buy only materials known to be preshrunk in manufacture; (2) to have laboratory tests for launderability made on samples before buying*

the fiber is carded until the actual weaving and lengthwise stretching of the cloth itself takes place. Furthermore, since many textiles are dried in a stretched condition, often in the presence of sizing, the yarns almost invariably maintain their length until they come in contact with moisture.

This leads directly to the conclusion, arrived at and proved at the American Institute of Laundering as well as in other laboratories in other parts of the country, that moisture itself is by far the most important factor in shrinkage. The presence of moisture permits fabrics which have been dried in a stretched condition to readjust themselves to their natural length.

It should also be noted in this connection, that the common belief that as the washing temperature is increased, the amount of shrinkage or contraction of cotton goods is increased, has been proved erroneous through repeated scientific tests. In one test, for example, four samples of cotton material 18 inches square were prepared, and squares of 12 inches marked off inside the larger area. Each sample was soaked in water for thirty minutes at one of the temperatures listed in Table I.

The test pieces were then air-dried and measured, with the results shown in this table. This brings out the following general conclusions: (1) Considerable shrinkage will occur in water only, regardless of the temperatures used, all washing supplies being absent. (2) An increase in the temperature of the water used does not have any marked influence on the rate of shrinkage.

Laboratory tests on shrinkage have also proved repeatedly that in the case of cotton and linen woven fabrics shrinkage depends largely upon the properties of the material itself. Table II illustrates this fact.

TABLE I—RESULTS OF A SHRINKAGE TEST OF COTTON MATERIAL

Temperature of Water	Shrinkage in Inches per Yard							
	1 Warp Filling		2 Warp Filling		3 Warp Filling		4 Warp Filling	
33° F. (ice water)	3.9"	0.6"	1.7"	0.2"	1.7"	1.0"	2.6"	0.9"
80° F.	3.8	0.8	2.4	0.2	2.2	0.9	3.0	0.9
120° F.	4.0	0.9	1.9	0.2	1.8	0.8	2.7	0.8
212° F. (boiling)	4.2	0.9	2.1	0.2	1.9	0.9	2.6	1.0

on the part of fabric manufacturers have made the latter idea untenable.

First, it should be understood that the amount of shrinkage in cottons and linens is, in most cases, inversely proportionate to the amount of shrinkage that occurred during manufacture. Textiles are stretched in varying degrees during the entire manufacturing process from the time

In this test fourteen measured samples of cotton toweling were soaked in a soap and builder solution at 140° F. for thirty minutes. The excess moisture was then squeezed from the towels, and they were again measured for length and width. The treatment that each test piece received was identical insofar as laundering method was concerned; hence the differences that occurred must be ascribed to a difference in the shrinking properties of the towel itself. In these test samples, the warp shrinkage varied from 0.36" to 2.73" for each yard of original material. In this partic-

TABLE II—RESULTS OF A TEST ON COTTON AND LINEN FABRICS

Towel Sample	Warp Shrinkage in Inches per Yard	Filling Shrinkage in Inches per Yard
1	0.36	0.50
2	0.54	....
3	0.72	....
4	1.26	....
5	1.80	....
6	1.80	....
7	1.80	....
8	1.83	0.72
9	1.90	....
10	2.23	....
11	2.41	....
12	2.52	....
13	2.52	....
14	2.73	....

ular test, only two samples developed a filling shrinkage, although other tests have shown this type of shrinkage not at all uncommon. Of course, in the case of a towel or a sheet, a few inches contraction in length may not be especially serious, but a similar shrinkage in a tailored article can hardly be disregarded by the buyer.

It has also been conclusively proved that the effect of laundry washroom supplies upon the shrinkage of cotton and linen woven materials is negligible. Table III shows the average results obtained in the case of four different samples treated with laundry supplies and identical samples soaked in water alone.

In other words, the presence of washroom supplies in laundering has little if any bearing upon the extent of shrinkage. Supplies assist in the removal of dirt, and because of their lowering effect upon surface tension unquestionably aid in thoroughly wetting textile materials with which they come in contact. Thus they may play a major part in removing sizing originally placed in the material, and thereby seem to cause in-

TABLE III—SHRINKAGE IN INCHES PER YARD

	1 Warp Filling		2 Warp Filling		3 Warp Filling		4 Warp Filling	
Water Only	4.0"	0.9"	2.1"	0.2"	2.0"	0.9"	2.7"	0.9"
Water Plus Supplies	4.0	0.9	2.0	0.15	2.0	0.9	2.8	0.9

creased shrinkage. However, it cannot be said that the ultimate shrinkage of any given cotton or linen woven fabric will be increased or decreased through the use of laundry washing supplies.

It follows, of course, that the greatest shrinkage occurs during the first washing but that additional shrinkage may occur through the second and third washing.

It should also be noted that when a hand iron is used in pressing cotton and linen fabrics, there is a tendency for the fabric to be stretched slightly. However, this stretching is never sufficient to overcome entirely anything but a slight shrinkage that has previously occurred in the washing process. The conclusions then, which have been reached in regard to the shrinkage of cotton and linen woven materials are:

1. There must be moisture present for shrinkage to occur.
2. The amount of shrinkage obtained varies with the material, depending upon the treatment that a given fabric receives during mill processing.
3. An increase in washing temperature does not have a marked influence upon the rate of shrinkage.
4. The presence or absence of washing supplies, has little effect upon shrinkage.
5. Shrinkage occurs regardless of the washing process used, unless the fabric being laundered has been properly preshrunk prior to tailoring.
6. The greatest amount of contraction normally occurs during the first laundering and unsized materials shrink rapidly.
7. The warp shrinkage generally is in excess of the filling shrinkage.
8. Pressing with a hand iron tends to stretch fabrics slightly but will not overcome excessive warp or filling shrinkages.
9. A gain in yardage during mill finishing means shrinkage during laundering.
10. Unless a wash fabric has been properly preshrunk, nothing can be done during laundering to prevent shrinkage.

These important conclusions on shrinkage, arrived at through repeated scientific testing, bring us to the general conclusion that if the buyer of cotton and linen woven materials is to secure fabrics that will assure true satisfaction, he must know that they have been properly treated and constructed in the first place. This, of course, admits of two solutions: (1) the purchase of materials known to be properly preshrunk in manufacture; (2) having accurate laboratory tests for launderability conducted on samples before purchasing cotton or linen materials.



# The Hospital Family:

## A Study in Adjustments\*

By JOSEPH C. DOANE, M.D.

TO OUTLINE definitely the point at which the work of the resident physician terminates and that of the nurse begins would represent a long step toward obviating much friction. This definition is not only difficult to make but difficult to follow. It is a real problem to secure individuals sufficiently pliable that they adjust themselves to their part in the complicated machinery of an institution.

The hospital is like a gossip small town. The idiosyncrasies of patients, their social prominence and their curious ailments with unusual complications; the success of a difficult operation; the obviousness of a diagnosis that was mistaken; the rumored engagement of a resident physician and an operating room supervisor; a dinner party of the superintendent, and the apparent failing vigor of the chief nurse all serve as morsels to be rolled under the loquacious palates of patients, doctors, nurses and even ward men.

Most of the gossip is harmless. A little is vicious. The frictionless operation of a hospital requires the smooth cooperation of all of its personnel to maintain its work at a high degree of efficiency. To accomplish this end the administrator must continually keep his directing hand on the controls.

### *The Resident Physician*

Hospitals frequently house two types of physicians — the resident and the intern. The resident physician is a graduate in medicine who usually has had a year or more of hospital experience. He is endeavoring to fit himself for the practice of a specialty. He is next in authority to the visiting physician and is his assistant in the performance of ward work. He frequently is assigned some administrative duties and serves as a liaison officer between the interns and the visiting staff. The intern, a more recent graduate of lesser years, is securing his first clinical contact with patients and is preparing himself for the practice of general medicine.

From an administrative standpoint, there are several types of nurses. The supervisor has ad-

ministrative nursing authority over a hospital department. A head nurse is usually assigned to a ward. Staff nurses furnish nursing care to patients. Pupil nurses are those of least experience.

The supervisory nursing staff answers directly to the directress of the school of nurses in administrative matters and to the visiting physician through the residents for the detailed bedside care of patients. Friction between the resident medical staff and the nursing staff is sure to create unhappiness, inefficiency and lowered institutional morale.

### *May Be a Stabilizing Force*

The resident physician is intent upon securing the greatest possible amount of experience. He secures surgical experience in accordance with the confidence he commands from the visiting staff. If properly selected and directed, a resident physician may serve as a useful stabilizing force in any hospital department since, except in non-rotating services, he is the only one who is assigned to a department throughout the whole period of his hospital stay.

From a selfish standpoint he soon learns that the value of his experience can be greatly augmented by the assistance and cooperation of members of the intern staff. Hence he is somewhat inclined to court the favor of members of the intern group for this reason. He therefore does not always serve as the most useful type of ward or department medical administrator. The resident physician frequently secures no recompense other than experience.

The chief resident physician, usually a salaried officer, is given authority over residents and interns. Often the smooth functioning of these persons depends upon his administrative skill if there is no medical director. The resident physician should be capable of performing emergency surgery, of deciding when to call members of the visiting staff and of furnishing supervision over such activities as the transfusion of blood, the

\*Practical Administrative Problems Series.

conduct of the accident ward and the efficiency of the ambulance service.

The psychology of the intern is interesting. He furnishes a certain youthful enthusiasm which is of much value to the hospital. In him are to be found educational opportunities which serve as a continual stimulus to the work of the staff. Fresh from the lecture hall and clinic he undertakes his service imbued with the idea that nurses are placed in hospitals to comply immediately with his commands.

He is half student, half professional man. He has for the first time an opportunity to issue orders, the soundness of which may be doubtful because of his lack of hospital and medical experience. He must often conceal from others that for a moment he is at a loss as to the proper course to pursue. For the first time he is greeted with that magic term "doctor." He has now reached his goal. He must command respect from all those with whom he comes in contact.

Figuratively wearing his feelings on his immaculately starched coat sleeve, he suffers, before many months in the hospital, grievous wounds to his pride. In some, one observes a violent explosion of words, in others a sulking, in others almost physical combat and in still others mental calmness and an attempt to interpret logically the motives underlying the actions of those around him.

#### *The Administrator Views the Intern*

The administrator notes with amusement the development of the medical character of the young intern. He sees him grow up. If he is a skilled executive he calmly catalogues each member of the staff and mentally, if not actually, notes the traits which he finds there. The skill with which this is done will determine the efficiency of the service of the intern group.

A quiet, studious, courteous intern staff is likely to reflect favorably on every other department in the hospital. Here is one intern who is unduly conceited, another who is self-conscious, another who is combative or aggressive, another who is hard working and conscientious and still another who is overly anxious to secure money and who may be morally uncertain and lack healthy personal traits. The disciplinary remedies to be applied must vary in every instance. The administrator, who with caustic sarcasm expects to create a subservient intern staff soon learns the fallacy of this program. Each demands and deserves special treatment.

If the intern fails to render satisfaction in the hospital he will fall short of success in his practice for the same reasons. Moral and personality de-

fects more often bring about professional failure than does a lack of knowledge of medicine. If the administrator observes selfishness and lack of appreciation of the rights of others, his remedy will be easily selected. If he discovers such personal defects in the intern as carelessness in dress, slothfulness in the performance of his duties, a tendency to indulge in alcoholics or to an excessive degree in play, the method of correction will be none the less easily forthcoming.

#### *What the Hospital Owes the Intern*

These matters have been considered in such detail because the hospital surely owes to the members of its intern staff a larger duty than merely for a period permitting them to examine and treat patients. Most institutions fall short of meeting this obligation because no chief resident physician is sufficiently skilled or interested to undertake this type of training. When an intern leaves the hospital, he should not only be well prepared medically but he should also have corrected or overcome personality defects and others which would hinder him in his future contacts with the public.

The administrator must not leave to a young chief resident physician this type of character training. The latter certainly is himself still in the course of training. The visiting physician in most instances does not possess sufficient time. To be sure, here and there one comes in contact with a distinguished internist or surgeon who one or more times during the year invites his interns to his home where matters far from medical are discussed. If this could be done more often the young physician would not be required to spend the first half decade of his career in learning expensive lessons which might have been imparted during his school and hospital life.

Group intern conferences and frequent friendly discussions of patients and their needs with the medical administrative officer are of the utmost value. Here can be pointed out the contribution of the social worker, the occupational therapist, the physical therapist. Here can be given information concerning many of the ethical and medical problems which will immediately confront the intern as he leaves the hospital to practice medicine. The intern is generally a well meaning, sensitive physician whose professional character can be easily moulded at this formative stage.

On his arrival at the hospital the intern discovers a person in white who, he has been told, is the nurse in charge of a whole hospital department. It has been whispered to him that she is either a good sport or critical of interns. If the latter is the case his defenses are up as soon as



he meets this nurse. He finds that she knows all the rules. It is from her that he receives his materials and instructions in the performance of his medical work. The supervisor, he learns, is the direct superior of the head nurse and all those under her. The skill and tact of supervising and head nurses in imparting the rules with which the intern unfortunately is usually not familiar will often determine the morale of the department.

He has been told that in order to maintain respect he must demand that nurses promptly obey his orders. Here he receives his first rude shock. He learns that there are matters which he may in no way change. He discovers for the first time that the technique taught to pupil nurses by their school instructress is as unchanging as the laws of the Medes and Persians.

He learns that a definite method of performing dressings has been adopted to which he must adhere. He often resents the arrival of mealtime when the attention of all nurses is devoted to the serving of food. He may not advance or delay this function. He may not alter visiting hours even though he is requested to do so by the relatives of his patients. He may not permit nurses to administer intravenous injections, hypodermoclysis or to perform extensive dressings. His reaction to these prohibitions will in a large measure reveal the breadth of his character and determine his future usefulness to the hospital.

#### *The Supervising Nurse*

The psychology of the supervising nurse is frequently as interesting as that of the intern. She often has spent many years in the hospital. Sometimes she appears to be too self-assured, too austere and too patently enjoying the authority given her. She may adopt a maternal, a pitying or a patronizing attitude toward the intern. She may even endeavor "to put the intern in his place," to show him that she is definitely and irrevocably in charge of her department.

When an intern of an aggressive sort meets a supervisor possessed of the same traits a resounding clash is likely to ensue which for sheer deadliness puts to shame the most active combats of war. Neither is likely to be mortally wounded but the patient who is an innocent bystander seriously suffers. If the superintendent of nurses supports her supervisor and the chief resident physician comes to the aid of the intern the hospital administrator is confronted by an interesting half-hour of court.

If he be skilled, he hears the evidence and adjourns the conference, later dealing separately with the ones who seem to be at fault. He never,

in the presence of both nurses and doctors, definitely places the blame. He does announce, however, that he is not interested in personalities, that he does not care whether intern A admires nurse B but that he will not permit friction and that he demands that both nurses and interns cooperate courteously or leave the hospital.

#### *The Head Nurse*

The head nurse is younger in experience and skill than the supervisor. She may be cooperative, understanding, flirtatious or quietly efficient. One may rightly ask whether the hospital does not expect too much of a young woman reared in a small town who after three years of institutional life as a pupil nurse is assigned administrative duties without proper preparation.

May the supervisor not too often be chosen for her excellence at bedside care and her high classroom grades rather than for her demonstrated administrative ability? She is expected to perform a multitude of duties which vary from the placation of irritable and irritated physicians to always meeting the public with an understanding and cheerful mien. In schools for nurses there exist certain class lines which seem not always necessary, and the semi-military discipline under which the frightened pupil nurse labors may at times amount almost to cruelty.

Both the pupil nurse and the intern in the early days of their hospital service are likely to come in close contact with death for the first time. That there is not always a kindly, experienced supervisor at the side of the young pupil when she is first asked to prepare the body of her erstwhile patient for removal to the morgue is a sad commentary on the lack of forethought and understanding which should be her right.

Interns do not always treat pupil nurses kindly. Frequently discipline and correction are carried out in the presence of others. She wonders whether it is disloyal to report to her supervisor what appears to be a dereliction of duty on the part of her colleagues or of interns. She hardly knows how to meet the demand on the part of a member of the visiting or resident staff that she break the rules in which she has been drilled.

The skilled administrator is the hospital equilibrator. It is he who endeavors to make practical the theoretical teachings of the educationist so that they meet the daily needs of the patient.

This conflict between the ideas and ideals of nurses and those of doctors of all degrees of experience is age-old. It is the dual place in the hospital of the nurse who must serve both as administrator and as bedside attendant which is likely to be misunderstood by the young intern.

# PLANT OPERATION . . . .

Conducted by John R. Mannix and R. C. Buerki, M.D.

## A Proposed Code of Safeguards Against the Anesthesia Explosion Hazard

By Victor B. Phillips

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[As a corollary to his article which appeared in this department last month, Mr. Phillips presents a code to be followed in order to lessen the explosion hazard.—Editor.]

**A** PROPOSED code of safeguards against the anesthesia explosion hazard should cover the following points:

### 1. Cylinders and cans.<sup>1</sup>

a. Anesthetic, oxygen, nitrogen, compressed air, and other such cylinders shall be clearly marked with name of contents. Distinguishing colors should not be depended upon.

b. Cloth covers shall not be used (may hide identification and may produce static).

c. All cylinders shall comply with the requirements of the Interstate Commerce Commission.

d. All cylinders shall be stored in dry, well ventilated locations, never in operating rooms, and only in an adjoining room if separated by blank walls.

e. Cylinders and cans shall be kept away from radiators, steam pipes and other sources of heat, and from possible contact with fire, electrical equipment, sparks and the like.

f. Except for low pressure oxygen containers such as are used in connection with pneumonia and similar cases, suitable regulators or other gas flow devices shall be used.

g. No equipment shall be used which would permit the intermixing of gases in various cylinders by any error of manipulation. If a cylinder of ethylene is accidentally connected with one containing nitrous oxide, for instance, an explosion would be almost certain.

### 2. Humidity and ventilation for all operating and anesthesia rooms and adjacent corridors.

#### a. All operating and anesthesia

<sup>1</sup>Taken from "Recommended Safeguards," 1929, National Board of Fire Underwriters.

rooms shall have atmospheric humidity maintained at between 58 and 63 per cent relative humidity, and all adjacent corridors at not less than 50 per cent.

b. All operating and anesthesia rooms and adjacent corridors shall have hygrometers reading directly in percentage of relative humidity. Same shall be checked at least every three months and, if necessary, calibrated by the whirling wet and dry bulb thermometer method.

c. Humidity control in operating and anesthesia rooms shall preferably be automatic.

d. If an air conditioning system is installed, recirculation shall not exceed 50 per cent of the air supplied. No recirculation is preferable.

e. If possible, ventilation by a supply and exhaust system shall be employed, of sufficient capacity to change the air in each room not less than every eight minutes and preferably more often in small rooms.

f. Ventilation should, if possible, be uniformly distributed and high velocity currents avoided. It shall be so directed that air flow past the head of the patient and the anesthesia machine is away from the operating table and away from cauteries and spark producing surgical equipment.

g. In the absence of an installed ventilating system, an electric fan may be used provided the motor is self-contained of type suitable for use in presence of inflammable gases and vapors (with fan blades and bearings of nonsparking materials and switches and plugs conforming to accepted vaporproof design). Such fan shall so direct ventilation as to carry gases from patient's head and anesthetic machine away from the operating table and from cauteries and spark producing surgical equipment.

### 3. Electric lighting and power.

In operating and anesthesia rooms, adjacent corridors and in any locations where combustible anesthetics

are stored, handled or used the following shall apply:

a. No electric motors except of vaporproof type<sup>1</sup> (see 4-a).

b. All switches shall be of approved vaporproof type. This applies equally to switches on portable equipment.

c. If vaporproof switches on apparatus cannot be supplied, then no switch shall be used and circuit closed through plugging in through vaporproof plug and receptacle.

d. All electric plugs and receptacles shall be of approved vaporproof type.

e. Electric lights for illuminating the operating room should preferably be enclosed by vaporproof globes, as this is the safest arrangement. Where ceilings are high, however, the vaporproof globes may be dispensed with, provided lights are protected by mechanical guards so as to minimize the danger of breakage and consequent possibility of thereby igniting vapors.<sup>2</sup>

f. Telephones, telephone bells or buzzers, and telephone ringing apparatus shall not be located in operating and anesthesia rooms, unless of type proper for use in presence of inflammable gases.

g. Exposed electric terminals or bare wires on equipment or elsewhere carrying house current voltages, viz., 110 to 120 volts or higher, shall be eliminated.

### 4. Cauteries and other electrical surgical equipment.

a. Whenever possible, only noninflammable anesthetics should be used when use of cauteries, electric diathermy, fulguration units and any other spark producing equipment is necessary. This applies to such items as the electric bone saw unless motor is vaporproof type and has sparkless bearings.<sup>3</sup>

Cauteries and spark producing equipment shall never be used in mouth, around head or pleural cavity, excepting the anesthetic be a noninflammable type. Simply removing the anesthetic equipment after using an inflammable anesthetic, or changing over to a noninflammable anesthetic is not sufficient because of the explosive mixture retained in patient's respiratory system.

b. A screen over the patient's chest shall always be used to keep anesthesia gases away from point of operation lower down on the body. Screen shall be full width of operating table, at least 15 inches high and fit closely around patient's body.

c. Low voltage equipment, such as examination lights and head lights

<sup>1</sup>Wherever the term "vaporproof" or "explosionproof" is used in this code, same shall mean the explosionproof type approved for use in Class I—Group D location by National Board of Fire Underwriters.

<sup>2</sup>Taken from "Recommended Safeguards," 1929, National Board of Fire Underwriters.

<sup>3</sup>In presence of such sources of ignition, inflammable anesthetics which diffuse readily (viz. ethylene) are more dangerous than ether which being heavier than air tends to drop to the floor.



shall be supplied with current from low voltage batteries, or if it is more convenient to use the lighting circuit current, then transformers shall be used having no metallic connection between the primary, connected to building light circuit, and the secondary, connected to the low voltage lamp. Rheostats shall not be used to secure the necessary voltage reduction.

d. Adjustment of voltage (and current) of cauteries shall be by means of variable ratio transformer having no metallic connection between primary and secondary.

#### 5. Open flames, lighted cigarettes and hot plates.

a. No open flame shall ever be permitted in operating and anesthesia rooms, and immediately adjacent corridor, or in any place where inflammable anesthetics are stored, handled or used.

b. No lighted cigars, cigarettes or pipes shall be permitted in such places.

c. If an electric hot plate or electrically heated sterilizer is necessary in an operating or anesthesia room, it shall be on a shelf at least 30 inches off the floor, and at least 10 feet from head of operating table, and, if possible, so located with reference to direction of ventilation that inflammable gases will not be carried toward the hot plate or electrically heated sterilizer.

d. A sign shall be posted in all operating and anesthesia rooms and adjacent corridors, and in all places where inflammable anesthetics are stored, handled or used, stating that open flames and smoking are prohibited.

#### 6. Grounding.

This proposed code does not recommend the general use of grounding for prevention of static sparks, but instead strongly recommends the use of humidity inside anesthesia equipment and in operating and anesthesia rooms as the only adequate protection against the static hazards. It is deemed unwise to use grounding for static prevention even though adequate room humidity is not provided.

#### 7. Gas regulators and manifolds.

Every precaution should be taken to ensure that gas regulators or other devices intended for use with a combustible anesthetic are not used on or with an oxygen (or nitrous oxide) cylinder or vice versa.<sup>1</sup>

#### 8. Oil or grease in oxygen lines and valves.

Oxygen ignites spontaneously with explosive force when in contact with oils or grease, hence extreme care should be exercised to prevent oxygen cylinders, regulators or pipes or tubes containing oxygen from coming in

contact with oil or grease on apparatus or machinery.<sup>1</sup>

#### 9. Warming anesthesia gases.

If heat is necessary to maintain an even flow of gas through the anesthetic apparatus, hot water bags only should be employed, or appliances of a type approved for use in explosive atmospheres.<sup>1</sup>

#### 10. Wool blankets, wool and silk clothing.

Wool is especially productive of static and will retain static charges at higher atmospheric humidities than are practicable. Wool blankets therefore are to be prohibited in operating and anesthesia rooms, as also outer wool clothing. Wool underclothing may also be dangerous, but being next to the usually moist surface of the body it is probably somewhat less dangerous than otherwise. Silk outer clothing shall be prohibited.

#### 11. Anesthesia equipment.

The following construction specifications and operating rules for anesthesia machines, gas supply tubes, breathing tubes, breathing bags and masks, shall be followed if possible:

a. Anesthetic gases, oxygen and air shall be bubbled through water in visible container preferably before mixing, but in any event before they pass into rubber breathing bag and breathing tubes.

b. A thoroughly wet sponge or 4 ounces of water shall be placed in breathing bag just before starting anesthesia.

c. It is desirable to moisten breathing tubes and mask inside and outside just before starting anesthesia.

d. In absence of adequate room humidity, a wet cotton bag over the breathing bag is desirable, and cotton covered breathing tubes which will retain initial moisture are preferable. However, if it be found impracticable to keep such cotton bag and tube covering moist during long operations it is better to dispense with them.

e. Metallic mesh or spiral wire in or on tubes leading to anesthesia machine from central supply valves shall not be used. The hazard of static on the outside of such tubes is not great whereas the danger of a short circuit or shock through such metallic circuit to ground is considerable.

f. Anesthesia machine shall be of the type for rebreathing. So far as consistent with the patient's requirements, rebreathing shall be used to the fullest extent.

g. All parts of machine, including valves, connections, tubing, ether jar gasket, and the like, shall be gastight and so designed as to remain tight.

h. A metal spirometer is preferable to a rubber breathing bag.

i. Means for carrying away anesthetic gases or vapors which would otherwise be exhaled into the room (viz., during induction) would be desirable if obtainable.

j. Design of pressure regulators, mixing passages or chambers and the like, shall be such as to preclude mixing under high pressure of an inflammable gas (such as ethylene) with oxygen (or nitrous oxide).

k. Mask shall be carefully fitted and tightly bound to patient's face to prevent escape of explosive mixtures.

l. When removed, mask shall be capped immediately with moistened rubber cap.

m. As quickly as practicable after use, anesthesia machine and breathing tubes and bag or spirometer should be flushed out with carbon dioxide.

n. Covers commonly placed over anesthesia machines shall not be used until after complying with (m).

o. No oil or grease shall be used on any anesthesia machine.

p. Spiral wires inside or outside of breathing or supply tubes shall not be used.

q. Particular care shall be exercised upon completion of anesthesia when mask is removed, that no source of ignition be permitted anywhere within say twelve feet of the patient's head until such time as the patient's exhalation of explosive mixture has been reduced below the explosive concentrations; and further that until this is accomplished the patient not be removed to another location where the proper precautions may not obtain. Pending more complete knowledge as to a proper time interval for the above, at least ten minutes is suggested.

r. The general standard or ideal to be approached in the administration of anesthetics should be the virtual elimination of the anesthetic from the operating or anesthesia room atmosphere. As such a standard is approached, the improper escape by leakage or otherwise of the inflammable gases will become detectable by smell and therefore subject to prompt correction.

#### 12. Inspection and testing of all operating and anesthesia room electrical equipment and circuits.

All such equipment and circuits shall be checked or tested every three months by a thoroughly competent electrician accompanied by the supervising nurse of the department of surgery. This should be done on routine schedule, that is to say a written outline of procedure including list of equipment or classes of equipment room by room.

Inspection shall cover all electrical fixtures and equipment of all voltages no matter how low the voltage. All loose contacts or terminals or those likely to become loose shall be corrected. All worn cords or wires shall be replaced. Particular attention shall be directed to the way in which cords or wires are brought out of the casing, box or enclosure of a piece of equipment to avoid sharp bends which

<sup>1</sup>"Recommended Safeguards," 1929, National Board of Fire Underwriters.

under flexing are likely to break through the insulation. Attention shall be directed to any violations of the electrical code, both national and local. The persons doing the inspecting shall check for compliance or non-compliance with the safeguards listed in this code.

Tests shall be made to determine the insulation resistance of all equipment, both fixed and portable, and the operating lights, both regular and emergency. In this connection, particular attention shall be directed to the insulation resistance of portable operating lights, head lights, examination lights, cauteries. It is to be remembered that with constant use, washing and sterilizing, the contacts, terminals and insulation may deteriorate rapidly between inspection dates. Although not particularly connected with the explosion hazard, this inspec-

tion may well include the operation of emergency lighting equipment for the operating room.

#### 13. Miscellaneous.

Ether shall never be used for washing purposes under any circumstances.

Specifications for construction of pipe lines for carrying anesthetic gases and oxygen to operating rooms from a central storage point are contained in the Report of the Committee on Gases of National Fire Protection Association for the Year 1934. This report also includes specifications for oxygen rooms and tents.

#### 14. Instruction of personnel.

All surgery personnel should be thoroughly familiar with all precautions to be taken against the anesthesia explosion hazard, and instructed immediately to report omissions, infractions and defective equipment.

still becomes discolored, or covered with dirt or dust. A great quantity of old dung that gradually passes into new shows that a large colony is still flourishing, while a few new droppings with the old prove that most of the rats have departed.

#### Clues in the Droppings

It is remarkable how many droppings a rat will leave in one day; from 30 to 180, when it is in captivity. The alvine discharge of the rat, like that of all rodents, is passed singly and at irregular intervals; it is scattered in a haphazard way, more numerous near the nest, on the runways, and where the rat has stopped for concealment, in secluded corners, under and over furniture, under drawers, under staircases, or in cupboards, and of course between walls and floors. A few small collections in widely separated places would indicate two or three rats. Widely scattered over a large area, they would suggest eight or ten or more, according to their freshness and other clues. The droppings are so important that the size, age and location of every one must be carefully noted.

The second clue is the runway. The spoor of the rat is distinctive, with the marks of the four toes of the forefeet. There is usually enough dust for the tracks to be visible, especially if it is illuminated from the side. The black rat often drags its tail, but the brown rat carries his an inch or more above the ground. A few tracks going straight here and there would belong to two or three rats; eight or ten would soon make a maze of them. But even one rat in time can make quite a number.

Like all colonizing animals, the rat always follows the same trail, soon establishing a runway. The constant passage of many individuals, each leaving a mark and many droppings forms a well worn track. As the body of the rat is a trifle oily, and usually dusty, it leaves a mark on the wall or pipe. One or two rats will soon make a clear trail; eight or ten, a big runway.

#### Where to Look for Runs

At first in our inspection we shall miss most of the runs, because we are looking down on the floor for them, while the rat travels overhead whenever it can. It ascends a pipe or even a vertical wall, "to follow the beams, leaving a dirty semicircular mark where it swings over the cross timbers," according to Williams. The run is the usually traveled road between frequently visited places, from harborage to feeding or drinking stations, and, less often, a general route connecting all harborages. It comes out in the open only when necessary, and then it will hug

## Pied Piper Plays Modern Tune

By Joseph N. Laferriere  
Consulting Entomologist, Boston

INSPECTION in rat control is just as important as in the control of roaches. The rat is the most elusive of household pests; therefore, baits or traps cannot be set at random with any hope of success. A precise knowledge of the rat's habits and activities is essential.

Let us follow a ratologist in his inspection of an infested building. Where a novice would notice almost nothing, the rat man will find clues everywhere. According to Dr. C. L. Williams, senior surgeon of Public Health Service, quarantine officers are so skillful in their inspection of a huge vessel that they can foretell in their reports the exact number of rats that will be recovered after fumigation, whether two or ten or thirty! A similar skill is useful in the inspection of buildings. Doctor Williams was the first to describe this part of ratology. The evidence of rat infestation, he says, "is in their droppings, runways, harborages, nests, gnawings, odor, live and dead bodies." A detective seldom has such a wealth of clues.

At the outset, the identification of species will offer no difficulty, because in nearly every case we meet only the Norway rat. The black rat has practically disappeared, save in a few colonies in seaports and in the South. In ships, on the contrary, about 99 per cent of the rat population belongs to the black type. The black rat has about the same habits as the house mouse and prefers the upper stories of the building, while the brown or

---

Even in rat extermination  
the old gives way to the  
new. In a series of two ar-  
ticles on this subject, Mr.  
Laferriere describes rat in-  
festation and raticides

---

the Norway rat will nest only in the basement or outside.

The most consistent and certain means of tracing rats is through their droppings. The droppings are easily recognized by their straight or curved spindle shape and by their rounded ends. Those of the mouse are of the same shape and color but smaller. The size also varies with the age of the rodent. A few large droppings, with a few small ones, will indicate the presence of a parent and its family, or from three to ten rats. When there are many large and small ones, there is of course a little colony.

The freshness of the droppings is another precious clue. When the dung is fresh, it is soft enough to be squeezed out of shape, and has a wet, glistening appearance. It dries up in two or three days and becomes harder. Then its surface turns dull, and later



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the shelter or shadow of the walls or pass behind boxes or barrels. Whenever possible, the rat goes between walls and floors, or even inside through the casings for wires and pipes. It even ascends a pipe on its hidden or interior side. The rat always takes the safest route.

The age of the gnawings is shown by the freshness of the bites and chewed particles. The musty odor of the rat is distinctive enough to be detected in a basement or a room or in the inside of a casing. Three or four dead bodies would indicate quite a colony. A few live rats, if seen, would have the same significance, because rats are so wary that only a few will show themselves.

At this point, the converging significance of these clues gives quite a picture of the rat population in the building. The line of demarcation between one and five rats is quite clear, but not so sharp between five and ten, or between fifty and one hundred.

If we now turn to the nests and harborages, we shall get a closer view of the life of the colony. The brown rat nests only in the basement or outside, because it is essentially a burrowing animal. It may enter a dwelling house in search of food, but it will dig its hole in the ground whenever it can. It will nest inside only in case of extreme necessity.

In warm countries, the brown rat's burrows are nearly always outside—under the barn or outhouse or buildings where the floor is only a few inches above the ground. Wooden sidewalks become veritable catacombs for rats. Rats also frequent basements and back areas covered with boards.

In cold countries, most of the rats take to the fields in the summer. The outdoor trails are much clearer, especially in the fields and river banks, and are well worn by constant passing and covered with droppings.

One of the principal tasks in rat control is the destruction of these harborages and the ratproofing of the building. All information relating to ratproof construction and repair is furnished on request by the Biological Survey, U. S. Department of Agriculture, Washington, D. C.

The runways of the rat will also lead to its drinking place. In the cities, the sewer usually becomes the main highway for the rat population. The brown rat is a real water rat, or at least semi-aquatic in its habits, and needs much water to drink and to bathe in. In cities, it is from these infested sewers that rats are likely to invade hospitals and other institutions. That is why outside trails are important in the inspection of a building.

Before any attempt is made at baiting or trapping, the rat man must observe certain precautions. The most important secret in rat control is to avoid handling the bait or the trap. The rat avoids the trap, simply be-

cause it usually reeks with human odor. The vaunted intelligence of the rat is nothing more than his sense of smell. If the bait or trap has the faintest taint of human odor, the rat will be frightened away.

Some wear gloves. I know of one man who passes his gloves over the first horse he can find, until they are thoroughly impregnated with a good "horsy" smell. Other exterminators put a few drops of aniseed oil on their gloves, or mix a few drops of this oil with the hands in a pound of oatmeal. This will remove all traces of perspiration and leave a delicate scent that is agreeable to the delicate olfactory nerves of the rat.

Luring is another old secret that

has been handed down from rat men to rat men. In some way or other it was discovered that the oil of rhodium had a peculiar attraction for the rat. It was used so extensively that it received the name of "oil of duty." It was distilled from certain rosewoods of the Canary Islands. Its odor resembles that of the damask rose. The supply ran out years ago, and now only the artificial rhodium is available. The commercial article is a mixture of cedarwood, sandalwood, palmarosa and geranium oils, the sandalwood producing the viscosity characteristic of the true oil. Here is a formula for artificial rhodium: rose otto, 3 parts; Spanish geranium oil, 3 parts; sandalwood oil, 6 parts.

## THE HOUSEKEEPER'S CORNER

- In spite of flood conditions throughout the state, the Connecticut chapter of the N. E. H. A. reported a good attendance at its meeting held at Grace Hospital, New Haven. At that time, Mrs. Gladys Hancock, president, was appointed as a delegate to the annual congress to be held in Chicago. Plans were also discussed relative to a combined annual meeting and dinner to take place on the third Saturday in June.

- At the April meeting of the Chicago chapter of the N. E. H. A. discussion centered around the forthcoming annual convention of N. E. H. A. to be held in Chicago, May 15 to 17. Three hospital housekeepers were nominated as candidates to fill vacancies that will occur on the national board of directors this year. The complete program of social and business activities for the convention will be ready for distribution May 1. This will be in the form of an attractive souvenir and will contain the history of the organization and photos of national and chapter officers. While the real business of the congress will not get under way until Friday, May 15, it is planned to have a conducted tour through the Furniture Mart and a luncheon there on May 14. Mrs. Marion Wyatt, president of the Chicago chapter, will be hostess at a dinner for the active chapter presidents that evening. Friday evening there will be a formal dinner and on Saturday evening an informal social entertainment.

- All roads led to Philadelphia on Saturday, April 18th, when Mrs. Doris L. Dungan, Jeanes Hospital, played hostess at the annual dinner of the Philadelphia Chapter of the N. E. H. A. Headliners were May A. Middleton, superintendent, Methodist Episcopal Hospital in Philadelphia and Anne Owens, former president of the national organization. Among those

participating in the festivities were Mrs. Gladys Hancock and Katherine Quinn from Connecticut. In addition to Miss Owens, New York was represented by Lucy Fogarty, Housekeeping Management Institute, *Hotel Management*.

- Always an unenviable position, those serving as judges for the educational projects submitted by members of the Philadelphia chapter of the National Executive Housekeepers Association found it extremely difficult to select from five which they considered the best. The projects were, therefore, turned over to a senior class in one of the courses conducted by Dr. Mary deGarmo Bryan, head of Institution Management, Teachers College, Columbia University, for final decision. The result was as follows: first prize "Floors," by Doris L. Dungan, housekeeper, Jeanes Hospital, Fox Chase, Philadelphia; second prize "Mattresses," by C. Muriel White, Washington Hotel; third prize "Linen Control," by Mary Hazelgrove, Germantown Hospital.

- Hail to a new chapter of the N. E. H. A.! Announcement cards bear the address "Baltimore, Maryland," but no details are available as yet regarding its size and date of birth. Predictions are, however, that it will carry great weight in that city and make itself heard throughout the country. At least seven hospital women officiated.

- At the Tri-State Hospital Assembly to be held in Chicago the housekeepers' session on May 6 will be opened by Dr. Gertrud Kroeger, research assistant in medical economics and hospital administration of the Julius Rosenwald Foundation, with a talk on the importance the hospital administration course at the University of Chicago places upon the housekeeping department in an institution.



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## The Dietitian as Sanitarian and Nutritionist

By Lulu G. Graves

Consultant in Dietetics and Kitchen Organization, New York City

**H**ENRY WARD BEECHER was once asked by Lyman Abbott, editor of *Outlook*, to write for that magazine an article pertaining to health. "An article on that subject is not needed," Beecher replied, and pithily summarized his creed in one sentence, "Eat well, sleep well, laugh well."

Science has made great advances in the prevention and treatment of disease since Beecher's time, but we still preach practically the same doctrine in present day health education.

Of primary importance to the dietitian is the first rule. Her chief purpose is to serve the right food to the various groups in the institution with which she is associated, but her program includes many secondary aims to which we shall give attention here. Sherman says, "Nutrition takes rank with sanitation as a major factor in that aspect of the health problem which consists in escaping disease." The influence of the dietitian as a sanitarian casts a long shadow. One sees it reflected in the morale of employees who work in clean, sanitary

surroundings conforming with the principles of personal hygiene.

Following the introduction of federal, state and city inspection, our milk, water and other supplies ceased to give us cause for concern. With methods of production and merchandising greatly improved, producers are able to furnish us good quality food materials in great variety. With the food purveyor, however, lies the final dispensation of the food. In the hospital this means the dietitian. Her knowledge of food composition, of food chemistry and bacteriology is applied to methods for keeping food fresh, free from contamination and at proper temperatures for cooking, storing and refrigeration.

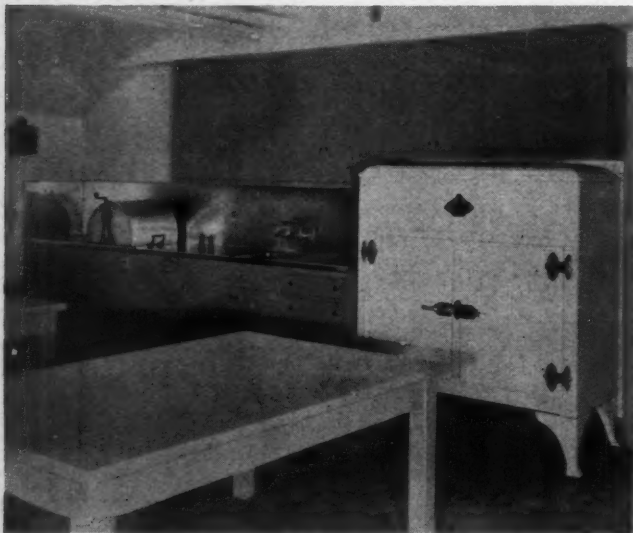
Foods are cooked for the purposes of sterilization and to soften their fibers, and different foods require different temperatures and methods if they are to be made palatable and digestible. These points need constant repetition in both teaching and practice. The practice of having all foods correctly cooked will be more convincing to the patients and personnel than

a whole series of lectures on the subject. For example, meat roasted at a low, even temperature remains plump, will not draw away from the bone, has less waste and its slices are uniformly pink circled with gray-brown. But when it is roasted at a high temperature, the entire slice becomes gray-brown except for a small circle of pink, or it is edged with a hard crust while the rest appears raw.

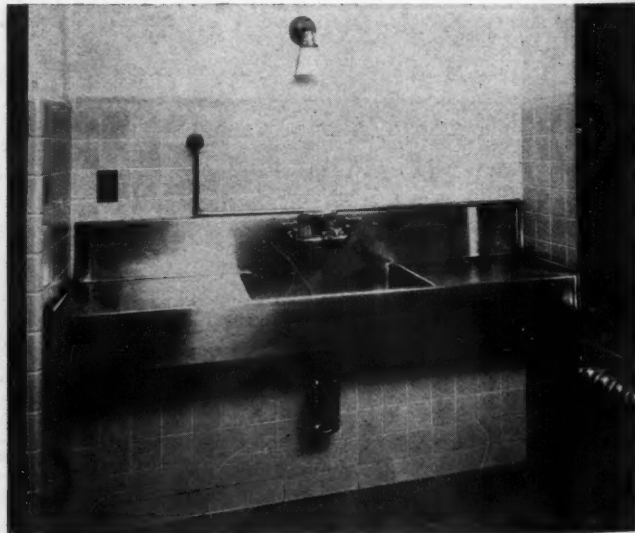
It is the bright green, yellow and red color of vegetables and fruits, together with their flavor and aroma, that give them their appetizing appeal. When correctly cooked they retain most of their color and flavor. When vegetables and fruits are cooked in water, some of their mineral salts and water soluble vitamins are extracted, therefore the cooking of green vegetables should be done quickly in order to retain as much as possible of these elements. The reason vegetables are unpopular with some people is that they have had experience with improperly cooked ones.

Correct temperature for cooking and storing does more than make food appetizing for waste is reduced and there is less danger of food contamination. Outbreaks of food infection or food intoxication are not frequent but when they do occur they are widely publicized. The possibility of food poisoning is a constant concern to one serving food in large quantities. Preventive measures are simple. They include only storing and cooking at the proper temperatures and cleanliness.

Although some bacteria are able to survive cooking, Tanner says that "it must by no means be regarded as a procedure without sanitary significance, nor should it be turned over to careless or disinterested persons." The last point should be given more consideration in many hospitals than it now receives. Besides dirt, there are yeasts, molds and bacteria in the



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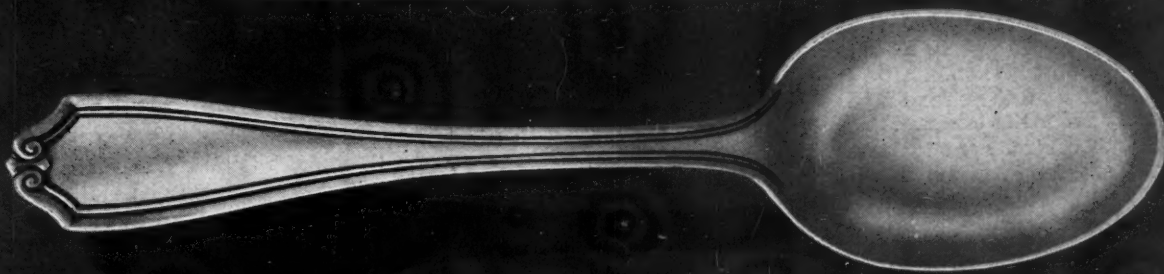
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air, water and soil, which multiply rapidly when conditions for growth are favorable. Not all are harmful organisms, but they make food unpalatable. They are destroyed by boiling for a specified time, strong sunlight and circulating air.

The hospital dietary department should be a model of cleanliness and sanitation. Kitchen and auxiliary rooms that have a good supply of windows so placed as to provide adequate light and ventilation are fortunate. A building of this type is a challenge to infectious diseases due to food. Despite the wonders of scientific investigation, no disinfectant better than sunshine has been found. Water is a first-rate cleanser and when boiling or in the form of steam it becomes a sterilizer. With sun and water abundant, inexpensive and easily obtained, the problem of a sanitary kitchen is greatly simplified.

Standards should be established for quantity as well as for quality. Standardization of portions begins with the purchasing of food and continues through its preparation by approved methods, cooking by tested recipes and serving in quantities determined by suitability to a particular need. Mechanical devices, such as slicing machines, cups and other utensils of uniform size, help in the standardization of portions.

Machines for the preparation of vegetables, for mixing, chopping, slicing and numerous other purposes, are valuable aids in the dietary department. However, unless they are kept well cleaned, oiled and in repair, much of their value is lost and the cost of operating them may become higher than is warranted. The estimated rate of depreciation on these appliances is 10 per cent, but with good care and reasonably careful usage they may survive a period of many years.

Manufacturers of kitchen equipment are collaborating to advance the culinary department. Stoves, sinks, dishwashing machines and other appliances are being built for utility and durability, but thought is also given to neatness of design and to ease of operation and repair.

#### Improved Ranges Now Available

Late models of ranges are greatly improved in all these respects and also from the standpoint of convenience in care and cleaning. With extra heavy oven insulation more heat is retained in the oven where it is needed and less heat is given off into the kitchen to cause discomfort to the workers. To cut off the flow of gas automatically when the burner is not lighted, and to control oven temperature, promotes safety, economy of fuel and more uniformly cooked foods. Flat tops and non-clog burners are other desirable features. These ranges re-

lieve the cook of constant attention to cooking processes, and their operation is not as complicated as it may appear.

Steam jacketed kettles of hard sheet aluminum throughout, either with pedestal base or tubular legs, are an improvement over those of a former design because of the greater ease with which one is able to clean around them, and their improved appearance.

Stainless steel or one of the alloy metals ensures long life and a minimum of care for sinks and tables. They are resistant to rust and other forms of corrosion and their beautiful finish adds a pleasing touch to the room. With well fitted corners, rolled edges and no seams, they are easily kept clean by ordinary washing procedure as there is no place for dirt to lodge or vermin to hide. In some sinks the bowl and drainboard are resilient enough to lessen the breakage of china.

Dishwashing machines have kept pace with other items of kitchen equipment in contributing features of significance in sanitation and health. Practically all standard types are now built of good materials with good lines and, as is true of most appliances, their construction provides for tightly fitted connections with no open corners or crevices. The mechanical processes for washing and rinsing vary in different machines, but in all of them dishes may be thoroughly cleansed, and sterilized to a certain degree.

#### Investigations on Sterilization

A number of investigations to determine how fully sterilization is accomplished have been made, and their results, as reported by Tanner, may be summed up briefly as follows: Careful washing will remove many bacteria mechanically; the nearer the temperature the washing water is kept to 212 degrees, the better the results; washing powders and sal soda are found to have appreciable bactericidal power.

These simple precautions are neglected in a large number of institutions. Cups, glasses and silverware are less likely to be sterilized than other dishes. Carelessness from two sources may explain this, as both are widely practiced. First, cups, glasses, spoons and forks are less likely to have particles of food adhering to them, and so they are rinsed rather than washed. Second, they may have been well washed, but workers are not taught to pick up silver by the handle or cups and glasses without touching the rims. Cups and glasses are generally inverted in baskets for washing and may easily be picked up by the bottom or the handle and placed on a tray or table without the top being touched. It is obvious that infection may be spread by dishes and silverware and that more attention

should be given this phase of preventive medicine.

The dishwashing machine itself must not be neglected, for accumulations of grease and food waste form rapidly. To prevent this the machine should be thoroughly washed in a strong cleansing solution daily and the tank for wash water cleaned, preferably with a brush, after each meal.

Where the dishwashing is not done in a central location, there are small machines designed for use in diet kitchens and serving pantries. These make possible the effective cleansing and sterilizing of dishes throughout the house. They may be installed in units including a sink, refrigerator and other equipment.

#### Dietitian's Influence Is Wide

Hospitals are planning new developments, reorganization and other improvements. These propitious circumstances may stimulate the dietitian to make her department outstanding not only within the institution but in the community. The reputation of the hospital is based as much on its dietary department as on any one thing. Therefore if a hospital becomes a center for instruction in nutrition and diets, its prestige in the locality greatly increases. The extent of this influence is governed by the quality of the food service, by the degree of order and system in the department, the confidence the dietitian inspires by her administration of daily activities and by her teaching of nurses, patients and those from the outside who look to the hospital for advice on this subject.

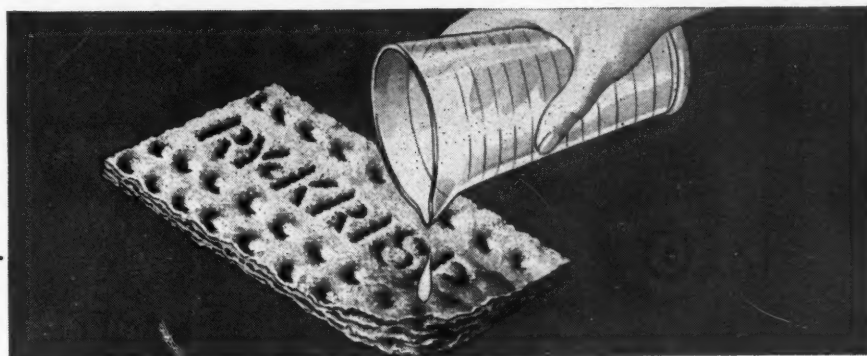
The report of the international commission of nutrition experts, formed by the League of Nations, which recently met in London and again in Geneva, calls attention to the prevalence of deficiency diseases throughout the world as a result of widespread malnutrition. It cites the great improvement in food production and, at the same time, stresses the fact that this alone will not bring about "improvement in the diet of the great mass of the world's population." This result can be attained only through rational diet based on a knowledge of the principles of nutrition. The commission gives recognition to the work of the dietitian individually and through the American Dietetic Association, and emphasizes the need for more extensive teaching of nutrition and diet to the members of the general public.

This education of the public can be accomplished through numerous agencies. Some of these were outlined in the symposium presented at the meeting of the community education section of the American Dietetic Association in Cleveland. The dietitian is only one factor, but she is an important one. Through her many of the



# Common Constipation

responds quickly to **RY-KRISP**  
a *natural* corrective



This is what happens when the liquids in the stomach come in contact with Ry-Krisp. Each wafer can absorb five times its weight in

water—producing bulk to stimulate peristaltic action. Its bran, pentosan and crude fiber content all tend to produce normal bowel action.

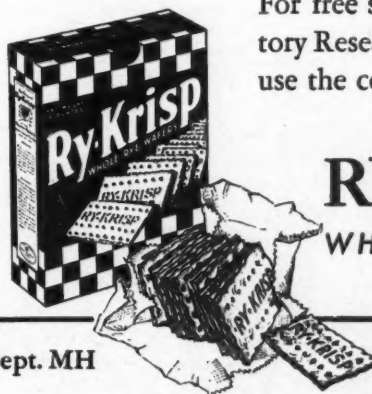
Because it is a tempting, highly palatable food which patients are *glad* to eat regularly, many physicians find Ry-Krisp ideal as a natural corrective for common constipation due to insufficient bulk.

Made simply of whole rye, salt and water—double-baked to tempting, brittle crispness—Ry-Krisp has a high percentage of bran, high pentosan and crude fiber content—all of which encourage normal bowel action. Moreover, its low water content (only 6.8%) and porous structure permit each wafer to absorb five times its own weight in water.

This produces needed bulk to stimulate natural peristaltic action.

The very fact that Ry-Krisp is such a pleasant alternate for crackers, toast or bread—at breakfast, lunch or dinner—is assurance of satisfactory results in the diet. Your patients—both children and adults—are *glad* to eat these crisp whole rye wafers regularly.

For free samples and the Laboratory Research Report on Ry-Krisp, use the coupon below.



**RY-KRISP**  
WHOLE RYE WAFERS

RALSTON PURINA COMPANY, Dept. MH

175 Checkerboard Square,  
St. Louis, Mo.

*Please send me literature and free samples of Ry-Krisp*

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

(This offer limited to residents of the United States and Canada)

unnecessary evils of malnutrition may be overcome.

Dr. Reginald Fitz states that "the need of work in other fields than hospitals has become recognized and there are many ways of applying dietetics in school, college, commercial or research work which were hitherto unthought of. Diets, foods and food values have come to occupy an important place in the minds of the general public. Both doctors and dietitians need to develop a critical attitude toward novelties in diets and dietetics, remembering that certain dietetic fads formulated without the most careful control are likely to be short-lived and will probably be of little permanent value."

Dr. E. V. McCollum says: "There is no field of knowledge in which there are so many self-appointed advisers who have judged their fitness for instruction on the basis of personal

experience, or credulous belief in attractively presented fallacy."

The lay person is befogged in his quest for information on this subject by the mass of written and spoken material from which he must sift the false from the true although he has no basis for judgment. Taboos are set up and perfectly good foods unjustly maligned by people who are more vocal than studious. Though there may be conflicting opinions among them, efforts should be made continually to impress upon the public the fact that those associated with hospitals and other institutions of good standing are the proper authorities to follow. The dietitian is in a strategic position to promote the truth through her hospital teaching and associations and by practical application at all times of the fundamental principles of nutrition and sanitation in her department.

his hospital care, the patient learns to take an active part in the program of watchfulness and care and to observe the changes in sugar excretion which may result from changes in diet before and after operations or from the shifting of insulin dosages.

### Qualitative Tests Made

Dependence on the examination of a single twenty-four-hour urine specimen has quite generally been abandoned in favor of qualitative tests on smaller specimens collected at definite hours throughout the day. The total twenty-four-hour amount of sugar lost has some importance in studies of the general efficiency of insulin or in computing the patient's tolerance, matters of more or less academic importance; but in the actual clinical management of a case, the important matter is to keep the urine free from sugar at all hours of the day, as judged by Benedict's qualitative test. This is usually a satisfactory indication of a normal blood sugar level.

Exceptions, in cases with disturbances of the renal threshold, require more frequent use of blood sugar estimations. To have sufficient data for intelligent variation of the diet and of the insulin doses it seems worth while to have urine collected in three-hour fractions between rising and bedtime, and in one fraction for the night. Six portions are thus tested for the presence of sugar. If quantitative data are desired, the mixed sample is available for a twenty-four-hour determination. Likewise the detection of ketosis is carried out on the mixed specimen.

In the Wisconsin General Hospital, Madison, two simple items of equipment have been found helpful in the program mentioned above. One is an individual refrigerator kept at the bedside, in which the urine specimens are collected for the entire day and the other is a metal test tube rack with an alcohol lamp and a supply of Benedict's reagent. The refrigerator is built of  $\frac{3}{4}$ -inch pine, lined with galvanized sheet steel and provided with a layer of corrugated paper as further insulation between the wood and the metal. The inside is divided into six compartments, each of which receives comfortably a liter bottle.

These bottles are wide mouthed, square, hold 32 ounces and are provided with metal screw caps. The shape is a decided advantage in lining them up in the laboratory or in storing them. They measure  $3\frac{1}{2}$  by  $3\frac{1}{2}$  by  $9\frac{1}{4}$  inches. Each bottle is marked for identification with a number painted on it with asphalt paint. The refrigerator boxes carry corresponding number schemes, a given number being assigned to each patient at the time of his admission to the hospital. In addition the spaces in each box are marked with the hours for the collec-

## Bedside Equipment for Teaching Self-Care to Diabetics

By Elmer L. Sevringhaus, M.D.

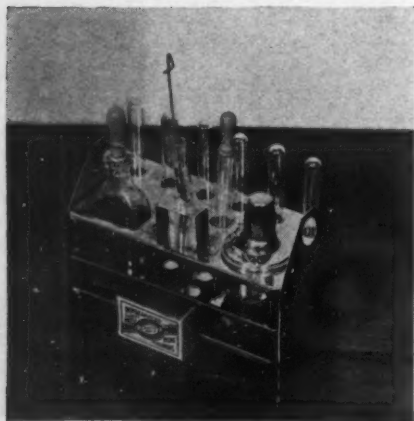
Associate Professor of Medicine, University of Wisconsin, Madison

ONE of the objectives in the treatment of patients with diabetes mellitus is to train them in adequate self-care under the supervision of the physician. During the preliminary period in the hospital, which is commonly used to teach the diabetic how to weigh food, test urine and administer insulin if that is necessary, these things are done for the patient by different members of the hospital staff. It is desirable that the diabetic should learn to carry out these simple procedures himself and to do them under

observation so that his technique may be improved before he is entirely on his own responsibility as an out-patient.

The regular testing of urine for the presence of sugar is one of the important items in this self-care. It seems simple and consequently a demonstration is often considered sufficient by both patient and physician. Errors may creep in, however, due to inaccurate measurement of urine or reagent, or to inadequate heating, incorrect interpretation of color changes without the presence of a precipitate and the false positive tests seen when urine volumes are low. These may be mentioned but forgotten when the diabetic is trying to learn so many details. At such a time he is apt to be disturbed by anxiety about a condition which has frightened him and made him consider his health a problem for the first time. Consequently it seems wise to have such a patient do his own urine testing repeatedly while under observation in the hospital.

The patient may be trained to test his own urine early in the course of treatment, and then allowed to do the testing without duplication by the laboratory technician as soon as he has demonstrated his proficiency. In addition to the economy thus achieved in



Bedside test-tube rack and testing set.



# Making the First Formula Agree with the Baby

NEWBORNS require breast milk. Deprived of human milk, their nutritional requirements are met by simple mixtures of cow's milk, sugar and water. The milk may be fresh, evaporated, dried, sweet or sour; the sugar simple or mixed.

Whole milk formulas are suitable for most newborns with good digestive capacities. The amount of whole milk given should approximate  $\frac{2}{3}$  of the total required calories. And the remainder (one-third) should be in added Karo. Water is added to the mixture for the fluid intake to be about  $2\frac{1}{2}$  ounces per pound of baby weight per day.

Evaporated milk formulas are indicated for newborns with limited digestive capacities. They may be used to advantage in considerably higher concentrations than whole milk for premature, feeble and debilitated infants.

The added Karo is again one-third of the total required calories.

Dried milk formulas are suitable for allergic infants who will take only small volumes at a feeding and babies of allergic parents. Formulas approximately equivalent to whole milk may be made up with water and Karo added in the same ratio as in whole milk mixtures.

Acid milk formulas are of particular value for babies with low digestive capacities requiring large food requirements. Acid milk requires no dilution with water.

## FORMULAS FOR THE NEWBORN

### 3 Ounces; 6 Feedings

Whole Milk . . . . .	10 ounces
Boiled Milk . . . . .	10 ounces
Karo . . . . .	2 tablespoons

Evaporated Milk . . . . .	6 ounces
Boiled Water . . . . .	12 ounces
Karo . . . . .	2 tablespoons

Powdered Milk . . . . .	5 tablespoons
Boiled Water . . . . .	20 ounces
Karo . . . . .	2 tablespoons

Lactic Acid Milk . . . . .	12 ounces
Boiled Water . . . . .	8 ounces
Karo . . . . .	2 tablespoons

## REFERENCES:

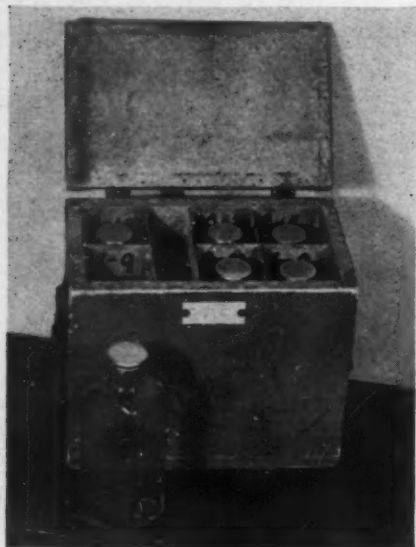
*Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott.*  
*Marriott, Infant Nutrition, Mosby.*  
*McLean & Fales, Scientific Feeding in Infancy, Lea & Febiger.*

The amount of Karo required may be added directly to the total volume of acid milk prescribed. Karo is an excellent milk modifier of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor) for both the baby and the budget.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. H5, 17 Battery Pl., New York City



tion of the specimens. The most convenient arrangement is from 7 to 9 a.m., 9 to 12 m., 12 to 3, 3 to 6, 6 to 9 and 9 p.m. to 7 a.m. Thus there are six bottles. A narrow seventh space in the box is filled with ice. The metal compartments communicate at the bottom and iced water keeps the urine from serious decomposition. An alco-



*Bedside refrigerator in which urine specimens are collected for the day.*

holic solution of thymol may be added to each bottle but is dispensable.

If the lid on the box is kept closed, ice needs to be added only twice in each day and no water need be drained out until the urine samples are removed for testing. These individual refrigerators measure 8.5 by 14 inches, are 11.5 inches high, and weigh 25 pounds when the bottles are empty. They are carried by folding handles on the ends. Each morning the orderly collects them and brings them to the laboratory for the urine tests. This scheme has eliminated putrid urines and has reduced to a minimum the mixing of urine specimens from different patients which may quite readily occur when many urine samples are allowed to collect in a service room.

The bedside test tube racks are made of sheet metal, as shown in the illustration. A 4-ounce bottle of Benedict's qualitative test solution is fitted into one space and a metal alcohol lamp into another. Between them is a holder for a small box of safety matches. Two test tubes carry an ordinary medicine dropper for measuring urine and a small test tube brush for cleaning the tubes. The Benedict solution is stoppered ordinarily with another dropper for measuring this liquid. In one row are found six test tubes, which are used for urine examination. The rack is marked opposite these tubes with numbers as follows: 7 to 9, 9 to 12, 12 to 3, 3 to 6, 6 to 9 and 9 to 7, the same intervals as those

provided for in the box refrigerators.

The test tubes in this bedside testing set are soft glass, 13 mm. in outside diameter and 125 mm. in length. With this small diameter the soft glass is amply durable for use in the flame. The choice of this sized tube was made to reduce the amount of reagent employed and the breakage loss from heating tubes in the flame and for economy in frequent testing. We direct the patients to use 20 drops of Benedict's solution and 2 drops of urine. The proportions are essentially the same as when 9 drops of urine and 5ml. of reagent are mixed in the

standard test. The results are read in the same way. This change in test tube size and in amounts of reagent has been adopted for hospital use also.

When the patient is taught to use the test tube over an open flame, such as an alcohol lamp, he needs to learn to avoid bumping and boiling the liquid out of the tube. He is therefore instructed to hold the tube in his fingers with the open end pointing into his hand and quickly learns to avoid bumping in order to spare himself. The tube is held almost horizontally, so that if bumping occurs the liquid will not be so apt to splash out of the tube. The tube is continually agitated while it is being heated. As soon as boiling begins the tube is raised so that its contents merely simmer. This position is held for two minutes by the watch. With these precautions the carrying out of the test is soon mastered. The patients then have a rack with six tests to exhibit to the physician at the time of his daily visit, an easy visualization of results.

## RECIPES BY REQUEST

Submitted by

**Lenna F. Cooper**

Chief, Department of Nutrition,  
Montefiore Hospital, New York City

### Blintzes

(Cottage Cheese Pancakes)  
(25 servings)

#### Batter

6 eggs, well beaten  
 $\frac{3}{4}$  pound flour  
 $\frac{1}{2}$  ounce salt  
 $1\frac{1}{2}$  pints water

#### Filling

$2\frac{1}{4}$  pounds cottage cheese  
3 eggs  
Salt and pepper to taste  
or 1 ounce sugar

Press cheese through colander, add eggs and season to taste. If a sweet pancake filling is desired add to the sugar a little grated lemon rind, vanilla or cinnamon.

Make batter by adding salt and water to eggs and stir into flour until smooth. Heat iron spider, grease well. Pour only enough batter into pan to make a very thin pancake, tipping pan in all directions to cover bottom. Bake on one side until it blisters, shake out of pan on board. Place rounded tablespoon of cheese mixture in center of each pancake. Fold over from both sides, then fold over top to form a three-inch square and fry on both sides until a golden brown. Serve hot, plain or with sugar and cinnamon.

### Palestine Soup

3 pounds Jerusalem artichokes  
1 onion  
1 bunch of celery  
2 quarts stock  
1 turnip  
Salt and pepper to taste

Peel and cut vegetables and boil in stock until tender; then rub through a fine sieve. Season with salt and pepper. The soup should be the thickness of rich cream. If not thick enough, a little potato flour may be added.

### Patient Responsibility

At the time of the visit a record of the results is made and the patient learns how the physician meets the occurrence of glycosuria, depending on the time of day it has been detected. The patient also soon comes to realize that his own progress depends in a large measure on his own cooperation and he knows that dishonesty about the diet shows results which can usually be detected at once. As soon as the patient shows himself able to reproduce the results of the laboratory technician, the bedside refrigerator is eliminated and the patient's results are used exclusively.

A somewhat frequent source of confusion to the patient is the obtaining of a false positive test for sugar due to the use of too much sugarfree urine or to overlong boiling. Again, this may occur when the urine is allowed to become too concentrated (that is, if the twenty-four-hour volume is much less than 1 liter), so that slight reduction of the reagent is due to high concentration of normal excretion products.

One of the fundamental lessons which diabetics need to learn is that they have health and safety more within their own control than is the case with most other individuals.

This scheme which we have found highly serviceable in the prompt and accurate management of diabetic cases has grown from the combination and adaptation of suggestions from several sources. Thus, acknowledgment is due Dr. I. M. Rabinowitch for the idea of bedside refrigeration of urine specimens; Dr. R. M. Wilder for the testing of urine at the bedside, and Dr. D. H. Duffie for the use of reduced amounts of urine and Benedict's reagent.



# CANNED FOODS AND THE PUBLIC HEALTH

## IV. BOTULISM

• Several of our readers have inquired as to the possibility of botulism resulting from the consumption of commercially canned foods. The canning industry is proud of the part it has played in the eradication from its products of this deadly type of food intoxication. We are glad to devote this space to a discussion of this important topic.

During recent years, the daily press periodically carries reports relating how one or more members of a family, or of a group of persons, were stricken after a meal, usually with fatal results. Sometimes these accounts describe how an "anti-toxin" was rushed to the scene—an indication that botulism was involved. These press reports often include the statement that a "canned food" was incriminated as the cause of the illness.

*We wish to emphasize that as far as the records go, these outbreaks without exception are not attributed to foods commercially canned in this country.* In practically every instance, it was found that the foods—usually of a non-acid or semi-acid nature—had been preserved at home by the use of inadequate heat sterilization processes (1). These press reports, by not stating correctly the type of food involved, have done much to cast unwarranted suspicion on commercially canned foods as possible causes of botulism.

Botulism, or acute toxemia due to *Clostridium botulinum*, is by no means a new affliction. As early as 1802—ninety-five years before van Ermengem discovered the true cause of the intoxication—warnings were issued against botulism. However, not until severe outbreaks occurred in this country some fifteen years ago, was it realized that cognizance should be taken of the fact that

foods canned by the methods used in those days could become contaminated with the toxin of this organism. This fact having been realized, the canning industry took immediate steps to prevent such contamination of their products.

Research was inaugurated and has been continued to which the industry has contributed not only financially, but also by the studies of scientists associated directly with the canning industry (2). The end result of these researches was the development of scientific methods of determination of heat sterilization treatments, or heat processes as they are known to the industry, which would be adequate to insure the safety of canned foods from the standpoint of botulism (3).

The effectiveness of the measures generally adopted by the canning industry of the United States is evidenced by the fact that no case of botulism attributable to an American commercially canned food has occurred during the past ten years (1a). Foods packed in commercial canneries are heat processed not only to insure protection from bacterial spoilage causing merely the loss of the food, but to render them safe from the standpoint of botulism, as well. In fact, a sterilizing process sufficient to insure the destruction of the most heat resistant strain of *Cl. botulinum* ever isolated is considered the minimum requirement of heat treatment of commercially canned foods. The National Canners Association has issued lists of scientifically determined processes for non-acid canned foods with which canners comply (4).

Such are the facts. The American canning industry offers its products to the consuming public for what they are; namely, wholesome and nutritious foods.

## AMERICAN CAN COMPANY

230 Park Avenue, New York City

1. a) 1935 Amer. J. Public Health, 25, 301  
b) 1935 J. Amer. Diet. Assn. 11, 18

2. 1936 J. Bacteriology 31, No. 1 P. 71  
1928 Amer. J. Public Health, 18, 108  
1922 J. Inf. Dis. 31, 650

3. 1929 Natl. Res. Council Bulletin, 7,  
No. 37

4. 1937 N.C.A. Bulletin 26-L,  
Revised

*This is the twelfth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.*



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

## Ice Cream Making Methods at Iowa Hospitals

By Kate Daum and Eunice Longworth

Director of Nutrition and Cafeteria Manager,  
University Hospitals, Iowa City, Iowa

Ice cream is one of the best liked desserts in the American dietary and in the hospital is liked or tolerated by the patient at almost any stage of his illness. The counter freezer with hardening cabinets instead of the expensive and space consuming hardening room makes possible good textured ice cream in small or large lots produced in the kitchen or pantry shop where supervision is easy. It is so simple in operation that highly skilled labor is not necessary for its manipulation.

The mix can be made in the hospital kitchen if a method of pasteurization is available. However, a commercial mix made according to desired specification as to butter fat, sugar and milk solids can be purchased just as cheaply. A commercial mix is homogenized so that the frozen product is smoother and always the same from day to day.

ICE CREAM COSTS			
Kind of Ice Cream	Add for 5 Gallons Ice Cream	Cost of Material Added to 5 Gallons	Total Cost of Ice Cream per Gallon*
Maple.....	Maple flavor 1½ oz.	\$.011	\$.037
Chocolate.....	Chocolate syrup 1½ qt.	.16½	.38½
Butterscotch.....	Butterscotch syrup 2 qt.	.14½	.38
Strawberry.....	Strawberry jam 1 qt.	.37	.42½
	or		
	Fresh strawberries 2 qt.	.25	.41
	Sugar 1 lb.	.06	
Pineapple.....	Crushed pineapple 2 qt.	.27½	.40½
Dried Apricot.....	Cooked, sweetened, dried apricot pulp 1½ qt.	.16½	.38½
Peppermint.....	Peppermint stick candy 2 lb.	.60	.47
	or		
	Peppermint flavor 1 tsp. and red coloring 1 tsp.		.36
Grapenut.....	Grapenuts 2 pkg.	.37½	.42½
Toffee.....	Toffee 1½ lb.	.60	.47
Banana.....	Bananas 1½ doz.	.30	.41
	Sugar ½ lb.		
Peanut Brittle.....	Peanut brittle 1½ lb.	.37½	.40½
Vanilla.....	Vanilla 2½ oz.	.02½	.35½

\*This is total materials' cost, salt, etc., not included.

Production under sanitary conditions, delivery at a uniform low temperature, and a low bacterial count are among the points that can all be included in the specifications.

In the University Hospitals, Iowa City, Iowa, a homogenized pasteurized mix containing 14 per cent butter fat delivered daily on contract by a commercial plant, is frozen in a counter freezer having a capacity of 5 gallons. An average of 65 gallons is frozen each weekday. The ice cream is frozen in bricks for the patients and in bulk for the personnel. The serv-

ices of a half-time man are required for freezing, delivering the ice cream and keeping equipment clean and in order.

The difference between the cost of the mix purchased and that produced and pasteurized in our own plant before the present plant's capacity necessitated the change, is insignificant.

With the mix at 70 cents a gallon as a basis, we have worked out the following table of costs per gallon of the various flavors of ice cream. Obviously these will vary with seasonal and local price variations. Cost of labor, equipment, repairs, and replacement averages between \$0.03 and \$0.04 per gallon.

An average overrun is secured.

## Should Dietitians Live in the Hospital?

The dietitian who lives outside the hospital will usually find that her interests are wider and her job less tedious, in the opinion of Bernice Levin Simmons, Beth Israel Hospital, Boston, writing in the *Journal of the American Dietetic Association*.

The long and intensive day of the dietitian should be lightened in her hours of relaxation in an atmosphere quite unrelated to hospital routine, Mrs. Simmons declares. It is natural that those whose work is engrossing should turn at the close of the day to scenes, activities and recreation totally different and quite remote from the atmosphere in which they work. Furthermore, it is not always desirable to live with those with whom we work.

Visiting hours in dormitories are limited, as are facilities for entertaining. This makes it difficult for the dietitian to reciprocate invitations to the homes of her friends.

## The Dietitian's Authority

Perhaps the most vulnerable department of the hospital from the point of view of public criticism is its food service, since every individual feels competent to comment upon the food set before him. In how many cases, however, is the head of this important department in a position to deliver the best possible meals on the patients' trays? No system will produce maximum results which does not invest the dietitian with full responsibility and authority for all functions entering into the selection, preparation, distribution and serving of the meals, including personal contact with the patients, thus establishing a direct channel for the transmission of complaints and suggestions to the head of the department chiefly concerned.

## FOOD FOR THOUGHT

● In the spring the dietitian's fancy may turn to thoughts of tray decorations, and May is a month in which she will have plenty of opportunity to try out any new ideas which may come her way. For example, on National Hospital Day, when all dietitians are usually trying to have everything especially nice, colored tray cloths or soufflé cases of contrasting colors add greatly to the attractiveness of the trays. The small cases may be filled with little candies, or if the larger cases are used, they may be filled with ice cream. For May Day, National Hospital Day or Decoration Day, little favors or flags may be stuck in the ice cream. These may be purchased at a paper store, or they can be made in the hospital, by pasting bright stickers on toothpicks. Crêpe paper flowers are also fastened on toothpicks, and may be used for decoration at any time.

● Phyllis MacDonald, of the Blodgett Memorial Hospital, Grand Rapids, Michigan, tells us they charge a flat rate of \$1 for a guest tray, regardless of the meal being served. The general diet is served. They also have a small guest dining room, which accommodates twelve, where à la carte meals are served at a very reasonable price. They find that this gives them an opportunity to make good use of leftovers.

● Years can be added to the life span by using the optimum diet, according to Dr. Henry C. Sherman of Columbia University. He recommends higher protein, more calcium, and more vitamins A and G.

● Lulu Graves has sent in the following notation in regard to the Low Cost Special Diet Manual prepared by the dietitians of Pennsylvania:

"A manual on low cost special diets for adults has been prepared by a joint committee of dietitians of the Dietitians Association of Philadelphia and the Pennsylvania State Dietitians Association. A market guide outlines an adequate supply of food at a minimum cost for families of different sizes for a week and for a normal diet for an adult. These form the basis upon which the special diets are built with as little change as possible in each instance to meet the requirements of specified diseases.

"The quantities of food suggested are given in grams and in household measurements. A few recipes are included with each diet list. The diets are designed as a guide for social workers, dietitians, nurses and others who contact adult patients with a low income—on relief or not. The manual can be obtained from Marion Bell, Temple University, Philadelphia, for 25 cents."



# A CUP OF GOOD HOT TEA



*Economical...Easy to prepare...And it offers untold benefits to convalescents*

Today, most hospital directors fully appreciate the benefits that convalescents derive from drinking hot Tea, properly brewed. It seems to have a strange influence over mood, a strange power of changing the look of things—and changing it for the better.

Hot Tea is of unquestioned value in soothing the nerves and arresting undue tissue waste. And as a patient's physical condition improves as a result of drinking Tea frequently, his mental nature is not quite so disposed to be fretful about conditions without or within.

Tea is easily digested. It stimulates the dull, calms the excitable, never interferes with restful sleep.

And since it is so economical, so quickly and easily prepared, Tea should be served several times a day as an aid to the more speedy recovery of all convalescents.

## *"The Best of Cocktails"*

—SAYS AN EMINENT  
LONDON PHYSICIAN

"Tea is a boon and a blessing  
and its effects are generally  
beneficial, conducive to con-  
tentment and clear thinking.  
It is the best of cocktails."

# Turn to **TEA** Today!

...THE GOOD BLACK TEAS OF  
INDIA, CEYLON, AND JAVA-SUMATRA

# June Dinner Menus for the Staff\*

By Angeline Phillips

Director of Dietetics, University Hospital, Omaha

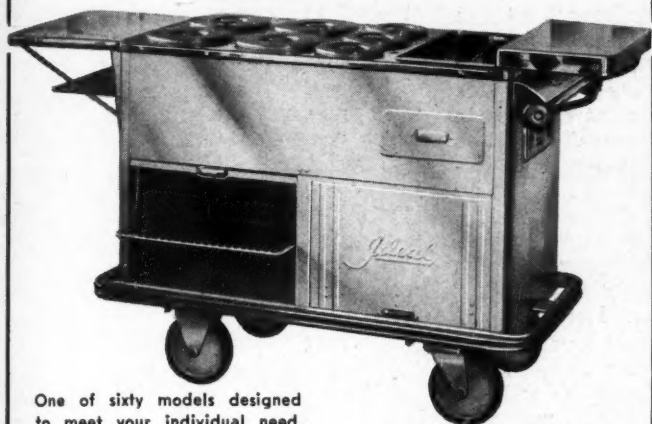
Day	Meat or Substitute	Potato or Substitute	Vegetable	Salad or Relish	Dessert
1.	Beef Meat Pie	Parsley Buttered Potatoes	Buttered Green Beans	Pear Pickle	Banana Gingerbread Shortcake
2.	Baked Pork Chops	Mashed Potatoes	Buttered Cauliflower	Lime Gelatine Pineapple and Cucumber Salad	Ice Cream, Butterscotch Sauce
3.	Braised Sweetbreads or Hamburg Patties	Baked Potatoes	Buttered Lima Beans	Spiced Whole Beets	Strawberries and Coconut Cake
4.	Baked Sweet Pickled Ham	Creamed Potatoes	Parsley Julienne Carrots	Head Lettuce, Roquefort Dressing	Pineapple Upside-Down Cake
5.	Fillet of Sole, Lemon Parsley Butter or Flank Steak	Stuffed Baked Potatoes	Asparagus, Hollandaise Sauce	Ripe Olives	Baked Lemon Chiffon Pie
6.	Veal Cutlets	Escalloped Potatoes	Buttered Spinach	Coleslaw	Orange and Banana Cup and Chocolate Cookies
7.	Rolled Rib Roast and Brown Gravy	Browned Potatoes	Buttered Green Beans	Stuffed Tomato Salad, Mayonnaise	Washington Pie
8.	Lamb Chop, Mint Jelly	Creamed Potatoes	Buttered Carrots and Peas	Cottage Cheese With Celery	Black Walnut Cake
9.	Roast Pork Butt and Brown Gravy	Mashed Potatoes	Buttered Beets	Molded Vegetable Salad, Mayonnaise	Pineapple Cubes With Mint
10.	Liver and Bacon or Chuck Roast	Baked Potatoes	Asparagus, Butter Sauce	Green Tomato Pickle	Baked Lemon Pudding
11.	Cubed Steak	Mashed Potatoes	Buttered Carrots	Watermelon Pickle	Chocolate Ice Box Dessert
12.	Salmon Pie With Baking Powder Biscuits		Buttered Green Beans	Pineapple and Cottage Cheese Salad, Whipped Cream Dressing	Gingerbread
13.	Smoked Tongue	Escalloped Potatoes	Buttered Peas	Vegetable Relish	Rhubarb and Soft Vanilla Cookies
14.	Chicken Fricassee With Baking Powder Biscuits	Parsley Buttered Potatoes	Asparagus, Butter Sauce	Head Lettuce, Chiffon Dressing	Strawberry Sundae
15.	Liver and Grilled Tomato or Roast Lamb	Stuffed Baked Potatoes	French Fried Onions	Gherkins	Raspberries and White Cake
16.	Chuck Roast and Brown Gravy	Mashed Potatoes	Buttered Beets	Cucumber Salad, French Dressing	Lemon Cream Roll
17.	Baked Fresh Ham	Creamed Potatoes	Buttered Lima Beans	Spiced Fruit Salad	Grapenut Meringue Butterscotch
18.	Veal Rolls With Bacon	Mashed Potatoes	Buttered White Kernel Corn	Health Salad, Mayonnaise	Orange Ice and Coconut Cake
19.	Boston Blue Fish or Mock Chicken Legs	Baked Potatoes	Parsley Buttered Cauliflower	Green Tomato Pickle	Cherry Upside-Down Cake, Cherry Sauce
20.	Ham Loaf	French Fried Potatoes	Asparagus, Hollandaise Sauce	Celery Hearts	Fruit Cup and Marguerites
21.	Baked Canadian Bacon, Spiced Peach	Creamed Potatoes	Buttered Cabbage	Head Lettuce, Roquefort Dressing	Chocolate Roll
22.	Roast Veal	Bread Dressing	Asparagus, Butter Sauce	Stuffed Celery	Pears and Filled Cookies
23.	Swiss Steak	Brown Rice	Green Beans in Cream	Fruit Salad, French Dressing	Macaroon Spanish Cream
24.	Pot Roast of Beef	Baked Potatoes	Buttered Cauliflower	Stuffed Olives	Deep Dish Rhubarb Pie
25.	Veal Paprika With Noodles		Buttered Peas	Coleslaw With Pineapple	Apricot Upside-Down Cake With Whipped Cream
26.	Baked Haddock With Lemon or Baked Flank Steak	French Fried Potatoes	Buttered Carrots	Asparagus Salad, French Dressing	Cream Puffs
27.	Meat Pie With Vegetables and Baking Powder Biscuits		Buttered Beet Greens	Cottage Cheese With Stuffed Olives	Watermelon Slices
28.	Baked Pork Tenderloin	Mashed Potatoes	Cauliflower, Hollandaise Sauce	Combination Vegetable Salad, Russian Dressing	Pecan Crunch Ice Cream
29.	Stuffed Cabbage	Candied Sweet Potatoes With Honey	Buttered Lima Beans	Mixed Pickles	Strawberry Pie
30.	Cubed Steak	Parsley Buttered Potatoes	Buttered Spinach With Egg Garnish	Celery Hearts and Gherkins	Cinnamon Blueberry Cake, Foamy Sauce

\*Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.



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**Kellogg's**  
**CORN FLAKES**

# NEWS IN REVIEW . . . .

## Crippled Hospitals Meet Emergencies of Flood, Fire and Tornado Successfully

Hospitals have written emergency history this last month. From New Hampshire to Mississippi death and destruction have stalked in the wake of flood, fire and tornado. Thousands of persons have been injured, water and food shortages have threatened, power lines have been broken, hospitals completely destroyed and temporarily crippled, but the personnel of these institutions have carried on under what at times have been almost primitive conditions.

When the tornado had passed over Gainesville, Ga., it was discovered that Downey Hospital, the only hospital in the city, had been so badly damaged that it was unable to render much assistance to the injured. News of the disaster was communicated at once to Atlanta and other neighboring communities and the Red Cross began its work. Emergency bases were immediately established at the clinics of the two mills left standing. From Atlanta came surgeons, interns, nurses, sterile supplies, surgical dressings, instruments and equipment for the establishment of first aid dressing and operating stations.

As much as possible of the Georgia State Tuberculosis Hospital, Alto, was

vacated and many victims were taken care of there by surgeons from Atlanta and Emory. Other victims were taken to the infirmary of Riverside Military Academy and later moved to Atlanta. Two special trains carried the injured from Gainesville to Atlanta where they were met by a fleet of ambulances from Grady Hospital, Fort McPherson and private establishments and taken immediately to Grady, St. Joseph, Georgia Baptist, Crawford W. Long and Piedmont Hospitals.

No one was injured at Downey Hospital, though the roof was taken off, all windows were blown in and the rear of the brick building was partially destroyed. In less than three hours the forty-four patients in the institution, along with what equipment remained usable, had been transported to the county's newly completed Alms House, where the hospital was temporarily reestablished.

"In addition to the fatalities and injuries caused by the violence of the storm itself," writes Dr. Russell H. Oppenheimer, dean of the school of medicine at Emory University, "there were many who suffered burns as a result of the fires that started immediately. Those who suffered no bodily

harm had great mental and emotional distress: for instance, I was told of one man, uninjured, who had lost his wife and two daughters. He went to a church which had been turned into a temporary morgue. With apparent calm he walked about among the dead, casually indicating to the attendant as he found each of his family. As he pointed out the third one he collapsed and had to be cared for in a first aid pavilion set up near by. Many sat unheeding in the pouring rain, too stunned to realize any physical discomfort."

At Tupelo, Miss., the hospital was so badly damaged that patients there were removed to emergency bases which were located at a theater, the courthouse and the city hall. The injured who could be moved were taken into Pontotoc for treatment. There were no lights whatever in the city, and rescue work was done by light from burning buildings.

### Flood Problems Well Met

Few hospitals suffered serious direct loss from the floods in the East. The Lee Homeopathic Hospital, Johnstown, reported damage estimated at \$20,000, the highest in Pennsylvania. Wayne County Memorial Hospital, Honesdale, Pa., figured its losses due to submerged equipment and supplies at \$5,000, while Renovo Hospital, Renovo, Pa., reported losses totaling \$2,500. The main worries of most hospitals were loss of light, power and the shortage of water. Emergency lighting units demonstrated their value at this time. Six emergency operations were performed in a hospital at Springfield, Mass., entirely by light from an emergency lighting battery system. At Johnson City, N. Y., one of these systems carried the total emergency load continuously for six hours. At the end of this time a small part of the regular service was restored but the hospital was forced to continue using the emergency system to supply power intermittently for five-minute periods until the alternating current was fully resumed. At no time during the crisis was power available for recharging the batteries.

Hospitals dependent upon the public utilities for light and power were entirely without these for a twenty-four-hour period in Allegheny County, the district which includes Pittsburgh. At the height of the crisis this loss added to the tension which accompanied the adaptation of facilities for disaster patients.

Ten emergency hospitals of twenty-five beds each were planned to take care of those who had lost their homes and were being cared for in Pittsburgh's concentration camps, but when Abraham Oseroff, president of the Hospital Conference of Pittsburgh and director of Montefiore Hospital,



*Two special trains carried the injured from Gainesville to Atlanta where they were met by ambulances and taken at once to hospitals.*



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expressed his opinion that the hospitals would be able to take on at least a thousand disaster victims, work on the emergency units was discontinued. A survey of the hospitals by Mr. Oseroff made a week after the flood, showed that 1,097 emergency cases had been handled and 676 disaster patients had been hospitalized. The survey showed that with some added equipment the hospitals would have been able to accommodate 1,147 patients and without it, 764. The survey also indicated that 174 cases of communicable disease could be accommodated in general hospitals, if necessary.

"It appears now," wrote Mr. Oseroff shortly after the flood, "that unless



*Emergency care being given to one of the injured by the light of candles.*

epidemic conditions should develop, and there is no specific indication of such at this time, our organized hospitals will have proved themselves ready and able to handle the entire load for hospital care."

Binghamton City Hospital, Binghamton, N. Y., was cut off from the water supply for thirty hours, was without gas for twenty-four and without telephone service for six. Large milk cans were secured from one of the dairies and water to be used restrictedly was hauled in trucks. An emergency wire was run to the hospital by the telephone company, so that the hospital had phone service when there was none other in that section of the city. The hospital has its own generating plant and so suffered no loss of electricity. Since most of its cooking is done with electricity there was little difficulty in the preparation of meals. Jerome F. Peck, superintendent, said that "while the hospital suffered some inconvenience there was really no hardship."

No hospitals in Springfield, Mass., were flooded, but the Springfield Hospital was within 200 yards of the water's highest level. Mercy, Shriners', Wesson Memorial, Wesson Maternity and Springfield Hospitals were all without electricity. Springfield

Hospital is equipped with steam turbines on its oil heaters and so used steam for heating purposes and for cooking, revamping the menus to fit the heat available.

"The first morning," Dr. Eugene Walker, superintendent, writes, "we lined up all available employees and had them take trays from the kitchen to the patients. After that we made each unit responsible for its own dishes and the kitchen concentrated on getting bulk food to the units. If there is one thing I learned in this emergency it was the advantages of decentralization."

Gas outlets in the laboratories were used for stoves during the day and for light at night, but a storage battery system gave the hospital illumination for the operating room, exit and night lights. The average census at Springfield Hospital is 215, but during the week of the flood it cared for an average of 275 patients, setting up beds in the sun rooms, doubling up the children, and placing adults in the children's ward. The laundry at this hospital was useless because of the lack of power and the Isolation Hospital cooperated by permitting the Springfield employees to use its laundry after hours, while a commercial laundry gave to the hospital a rate close to actual cost during the emergency.

Hospitals in Hartford, Conn., were outside of the flood area, but most of them suffered from lack of light and power. St. Francis' Hospital, equipped with an emergency lighting system that went on automatically when the regular power gave out, carried on with little difficulty.

### St. Louis Establishes Group Hospital Service

The middle of March saw the establishment of a group hospitalization plan in St. Louis under the direction of Ray F. McCarthy, executive director. Sixteen hospitals, each accepted by the American Medical Association and approved by the American College of Surgeons, have become members of the association.

Mrs. Edward J. Walsh, a St. Louis philanthropist, is president of the group hospital service; Frank C. Rand, president of Barnes Hospital, and Dr. Major Seelig, representing the medical society, are vice presidents; Alphonse M. Schwitalla, president of the Catholic Hospital Association, is secretary, and Leo Fuller, civic leader and philanthropist, is treasurer. E. E. King, superintendent, Missouri Baptist Hospital, is a member of the executive committee and E. Muriel Anson, superintendent, Jewish Hospital, E. E. King and Father Schwitalla are members of the board of trustees.

The plan, which is a component of the Medical Economic Security Administration, has an administrative board of fifteen members, and, according to its by-laws, three of these must be hospital administrators and three must represent the St. Louis Medical Society. The subscribing hospitals are Alexian Brothers, Barnes, Bethesda General, Christian, Evangelical Deaconess, De Paul, Firmin Desloge, Jewish, Lutheran, Mount St. Rose, St. Mary's, Missouri Baptist, St. Anthony's, St. John's, St. Luke's and St. Mary's Infirmary.

### Duke Endowment Announces \$866,244 in Appropriations

Appropriations totaling \$866,244 were made for hospitals in North and South Carolina by the trustees of the Duke Endowment at a recent session. Of this amount seventy hospitals in North Carolina receive \$522,475 and 33 hospitals in South Carolina receive \$343,769.

These appropriations bring the total amount paid to the hospitals in these states since the foundation of the fund on December 11, 1924, to \$9,296,083.84, with \$6,694,291.95 being used to furnish care for free patients and \$2,601,791.89 for equipment.

Among the largest allotments to hospitals were \$69,375 to the Duke Hospital, Durham, N. C.; \$33,121 to Columbia Hospital, Columbia, S. C.; \$71,818 to Roper Hospital, Charleston, S. C.; \$22,289 to the Shriners' Hospital for Crippled Children, Greenville, S. C.; \$25,283 to Watts Hospital, Durham, N. C.; \$21,873 to the City Memorial Hospital, Winston-Salem, N. C.; \$20,180 to the Highsmith Hospital, Fayetteville, N. C., and \$20,336 to Lincoln Hospital, Durham, N. C.

### \$292,438 Deficit for N. Y. Catholic Hospitals

Twenty-three Catholic general and special hospitals in the New York archdiocese sustained a deficit of \$292,438 during 1935, largely through the care of charity patients to whom 350,000 days of free care were given.

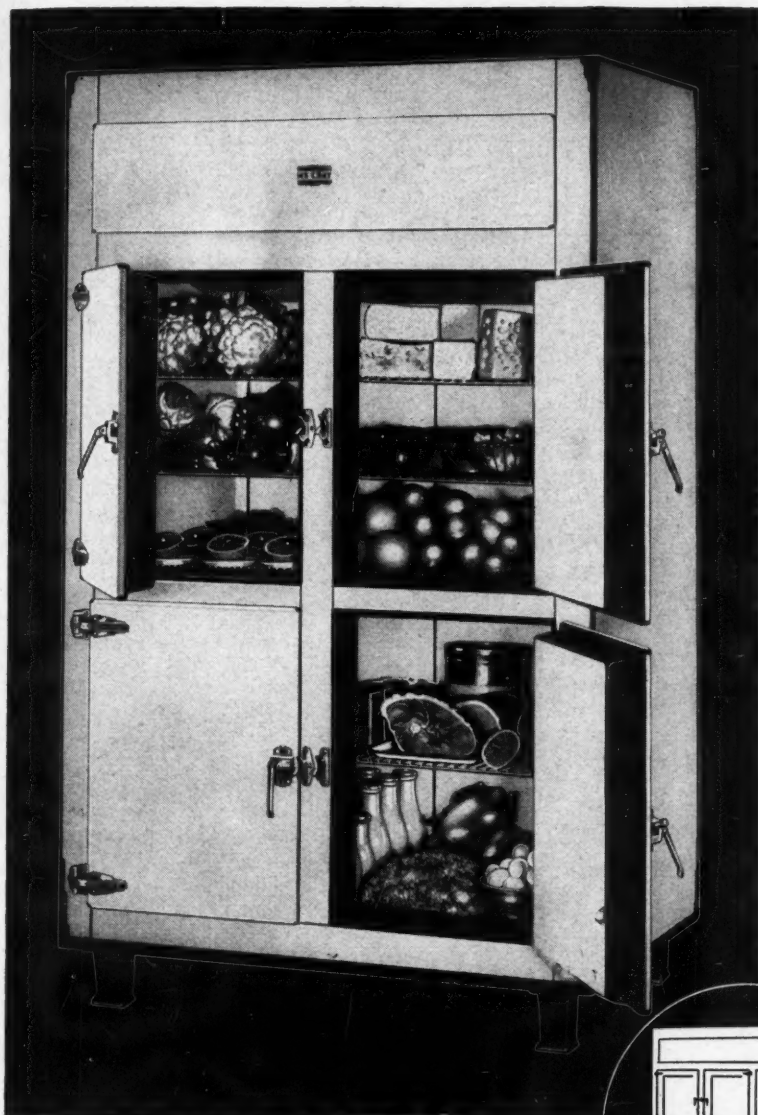
According to a report made public by Monsignor John F. Brady, director of the division of health of the Catholic Charities of New York, these hospitals cared for 58,000 in-patients and 42,000 out-patients, giving a million and a quarter days of care to in-patients alone, an increase of 3,300 patients and of 37,637 days of care over 1934.

Owing to increasing operating deficits highly important purchases and expansions are being postponed.



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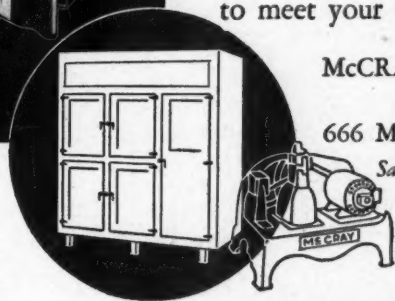
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# Compulsory Health Insurance Act Passed by British Columbia Legislature

The first provincewide compulsory health insurance act to be passed by any legislature on the North American continent was enacted on March 31 in British Columbia. The act has not yet been proclaimed. After proclamation occurs, a health insurance commission will be appointed, and several months of detailed planning will be required before the system is put into operation, according to Allon Peebles, adviser on health insurance, office of the provincial secretary.

The plan provides that the most essential medical services will be available for employees and their families, at an average cost of about forty cents a week to the wage earner. It is estimated that the number of employees to be covered will be about 110,000 and the number of dependents 165,000, making a group of 275,000 insured persons in all.

Medical care by the physician or surgeon chosen by the insured person, free hospital care, the services of diagnostic laboratories and necessary drugs and medicines are the mandatory benefits specified in the act. Various other medical services may be granted as permissive benefits if sufficient funds are available after payment for the mandatory benefits.

A striking feature of the act is that it deals with the family as a unit. Dependent wives and children are to be included as insured persons.

## Eligible Under Plan

The plan is to cover all employees earning less than \$1,800 a year, except farm workers and Christian Scientists, who are specifically excluded. Certain other employees, such as domestic servants, casual workers and part-time workers may be excluded, if the health insurance commission decides and the government approves.

An additional exemption provision of great importance is that employees who are members of any industrial medical service scheme in existence on January 1, 1936, shall be excluded if their scheme provides a standard of service equal to or better than the services of physician and hospital for all cases of ordinary illness. However, if a majority of the employees who are members of such a scheme vote to come within the scope of the provincial scheme the exemption of any such group of employees is to be rescinded. Thus employees belonging to an industrial medical service scheme that maintains good standards are to have an opportunity of choosing between their company scheme and the provincial plan.

In view of the fact that some industrial medical service schemes may

cease operations after introduction of the provincial plan, the act provides that members of these schemes earning from \$1,800 to \$3,000 a year may be included in the provincial plan as well as those earning less than \$1,800.

Provision is also made for the inclusion of other persons, such as merchants, farmers and others not working for wages, irrespective of their incomes, who may join the scheme as voluntary contributors to obtain benefits for themselves and their dependents.

## Not Financed by Government

The plan is to be financed by contributions from employees and employers, without any contribution from the government. The government, however, has appropriated funds to cover the organization expenses of the health insurance commission. The employee is to pay 2 per cent of his wages and the employer 1 per cent of his pay roll for insured persons, with minimum and maximum contributions fixed for each. The minimum contribution for the employee is to be 35 cents a week (or some smaller amount to be fixed by the commission), and his maximum contribution 70 cents; while the employer's minimum payment for each employee is set at 20 cents a week and his maximum payment at 35 cents.

An important provision for employers is that they will only have to make contributions in behalf of employees who are insured persons. The commission is authorized to work out special methods of payment for seasonal workers such as loggers and fishermen. Voluntary contributors are to bear the full costs of the services rendered to them and their families, and rates are to be fixed by the commission, with the approval of the government.

The plan is designed to interfere as little as possible with existing methods of providing medical care. Thus it is provided that except under unusual circumstances insured persons shall have the right to obtain service from the physician or surgeon of their own choice. They are also to be entitled to have prescriptions filled by any qualified pharmacist.

Hospital service in a public ward is to be given for a period not to exceed ten consecutive weeks for any one illness, unless a longer period is authorized by the commission. Those who desire semi-private or private ward care may obtain this by paying the difference between public ward rates and other rates.

Full laboratory service and diagnostic aids, including x-ray, biochemical and other services, are to be provided without special charge. However, in

the case of drugs, medicines and dressings it is specified that the commission may require the insured person to pay not more than one-half of the cost of these items.

Power is given to the commission to expand the list of medical services to the extent that finances permit. Benefits are to be granted to insured persons four weeks after contributions in their behalf become payable. They are to continue eligible to receive benefits for so long as their contributions continue, for four additional weeks, and for any further additional period that may be specified by the commission. If an employee falls ill and is unable to work he will be entitled to receive medical care for a still further additional period of twelve weeks.

These provisions mean that beneficiaries of the scheme will receive benefits not only while they are contributing, but also during short periods of unemployment and during a considerable period of absence from work on account of sickness.

The commission is to make its own financial arrangements with doctors, druggists, hospitals, laboratories and other persons or agencies providing services. In the case of doctors, any one of three methods of payment may be used, a salary system, a per capita system or a fee system with an allotted pool of money. If the per capita or the fee and pool system is used it is provided that there shall be set aside for the payment of doctors not less than \$4.50 per insured person per year.

## Administering the Act

The act is to be administered by a commission to consist of a chairman and not more than four other members. The chairman, who is to devote his full time to the work, is to be the chief executive officer. The other members of the commission are to give only part-time service. A full-time vice-chairman may be appointed to assist the chairman in executive duties.

The act also provides that the government may appoint a technical advisory council of not more than six members to serve without remuneration and to advise and assist the commission. On this council there is to be the provincial health officer, the chairman or some other representative of the workmen's compensation board, a physician with experience in private practice and at least one woman.

While the commission is given broad powers to work out the details of administration, regulations are to be made only with the approval of the provincial government.

Many of the provisions of the act are drawn from or are similar to those in the British Columbia workmen's compensation act. The existing system of workmen's compensation will not be disturbed by the insurance plan.



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## Ohio Association Appoints Ralph Jordan Full-Time Executive Secretary

Another step forward in the growth of the Ohio Hospital Association was made public at the recent convention of the association in Columbus when it was announced that Ralph W. Jordan of Cleveland had been appointed full-time executive secretary. Ohio thus becomes the first state hospital association to employ an experienced man as full-time executive officer. Mrs. Lucille Brick, who has been full-time assistant secretary during the past two years, will continue in that capacity under the new arrangement.

Mr. Jordan for the last two years has been chief of the field division of



Ralph W. Jordan

the U. S. Internal Revenue office in Cleveland, responsible for twenty-eight Ohio counties. Prior to that he was business manager of the Cleveland Tuberculosis Sanatorium at Warrensville, Ohio. He entered hospital work through his office as district manager for Ohio of the Professional Finance Corporation, and has had extensive legislative experience.

The Ohio convention combined meetings of the hospital, dietetic, record librarians, nurse anesthetist, obstetrics, clinical laboratory technicians and physiotherapists associations.

Outstanding among the papers was a discussion of food production by M. Faith McAuley, administrative dietitian, Illinois Emergency Relief Commission, Chicago. Proper kitchen layout, choice of suitable equipment fabricated from proper materials, adequate use of the bake shop, the shop for frozen products and the laundry are all important elements of food production, Miss McAuley declared.

Food production, she said, must begin and end with a menu but menu building can only be intelligent when it is based on a thorough knowledge of markets and methods of production as they affect consumption. To illustrate her point, Miss McAuley presented charts showing the producing season on various products, for example, most spinach is produced and shipped from December to April and most cauliflower from October to

March. Standardized recipes are important to the dietitian, she said.

A series of papers on the opening day outlined the relations of hospitals to the state health department, the industrial commission and to other arms of the state government. Dr. Fred Carter, president, American College of Hospital Administrators, outlined the work of that organization and declared that its program in Cleveland next fall will be built around the report of the committee on training hospital administrators.

The possible shortage of nurses in Ohio again came up for discussion. Clara Brouse, chief examiner of the department of nurse registration of the Ohio State Medical Board, reported that questionnaires had been sent to all the hospitals with accredited nursing schools in the state. From these 72 hospitals, 45 superintendents of nursing reported that there were enough registered nurses in their communities, 22 reported that more were needed and two stated that their communities had too many nurses.

Evidently the oversupply of nurses in Ohio has diminished markedly during the last year. A questionnaire sent out by Miss Brouse to the same schools a year earlier brought reports that more nurses were needed in only twelve communities then while twenty-six communities reported an oversupply.

### Dr. Buerki Conducts Round Table

In a joint round table with the record librarians conducted by Dr. R. C. Buerki, president, American Hospital Association, one of the questions discussed was the combination of duties in small hospitals. Record librarians from various small hospitals reported that they also do nursing, write histories, admit patients, handle collections and financial records, serve at the switchboard and act as x-ray technicians. In a discussion of nomenclatures most hospitals reported that they had adopted or were planning to adopt the Standard Classified Nomenclature.

In a report on the clinic situation in Dayton, where all clinics were closed at the request of the medical profession, Dr. E. R. Crew, Miami Valley Hospital, said that a survey of 200 families by the medical society had indicated that no patients were failing to get needed service.

Guy Clark, executive secretary of the Cleveland Hospital Council, was installed as president succeeding Dr. M. F. Steele of Columbus. Olive Jane Brown, De Ette Harrison Detwiler Memorial Hospital, Wauseon, was chosen president-elect.

## Southern Associations Hold Tri-State Meeting

The Tri-State meeting of North and South Carolina and Virginia hospital associations was held at Old Point Comfort, Va., April 16 and 17, with the members of Virginia State Dietetic Association as guests. The meeting opened officially on Thursday morning with a discussion of centralized tray service by Helen Gilson, Pennsylvania Hospital, Philadelphia, and decentralized tray service by S. Margaret Gillam, New York Hospital, New York City.

That members of the intern staff should be considered students and everything possible done to make their fifth year valuable was emphasized by Dr. C. S. Lentz, University of Virginia Hospital, Charlottesville, in his paper on "The Hospital's Obligation to the House Staff." Anne F. Parsons, Medical College of Virginia, proved definitely that the eight-hour day for private duty nurses resulted in more calls for these nurses than were made under the twelve-hour plan. Tact and good judgment were stressed as necessary in the successful operation of an admission department by Sample B. Forbus, Watts Hospital, Durham.

Considerable discussion was aroused by J. Ambler Johnston, Richmond engineer, who stated that in the future hospitals will be insulated against heat and cold and sound; that windows will admit light but not heat, and that heat will be furnished through hot water or hot oil rather than steam. He also prophesied the replacement of other types of heat by electricity for cooking and sterilization and the complete air conditioning of the buildings.

Dr. Lewis E. Jarrett, Medical College of Virginia, was elected president of the Virginia Hospital Association. Dr. W. N. Walter, Lewis-Gale Hospital, Roanoke, and C. B. Short, Jefferson Hospital, Roanoke, were elected vice presidents and M. Haskins Coleman, Richmond Hospital Service Association, secretary-treasurer.

The North Carolina Hospital Association elected Dr. M. S. Martin, Martin Memorial Hospital, Mount Airy, president; Dr. Robert T. Ferguson, Charlotte, vice president, and M. E. Winston, Rex Hospital, Raleigh, secretary-treasurer. The South Carolina Association will elect officers later.

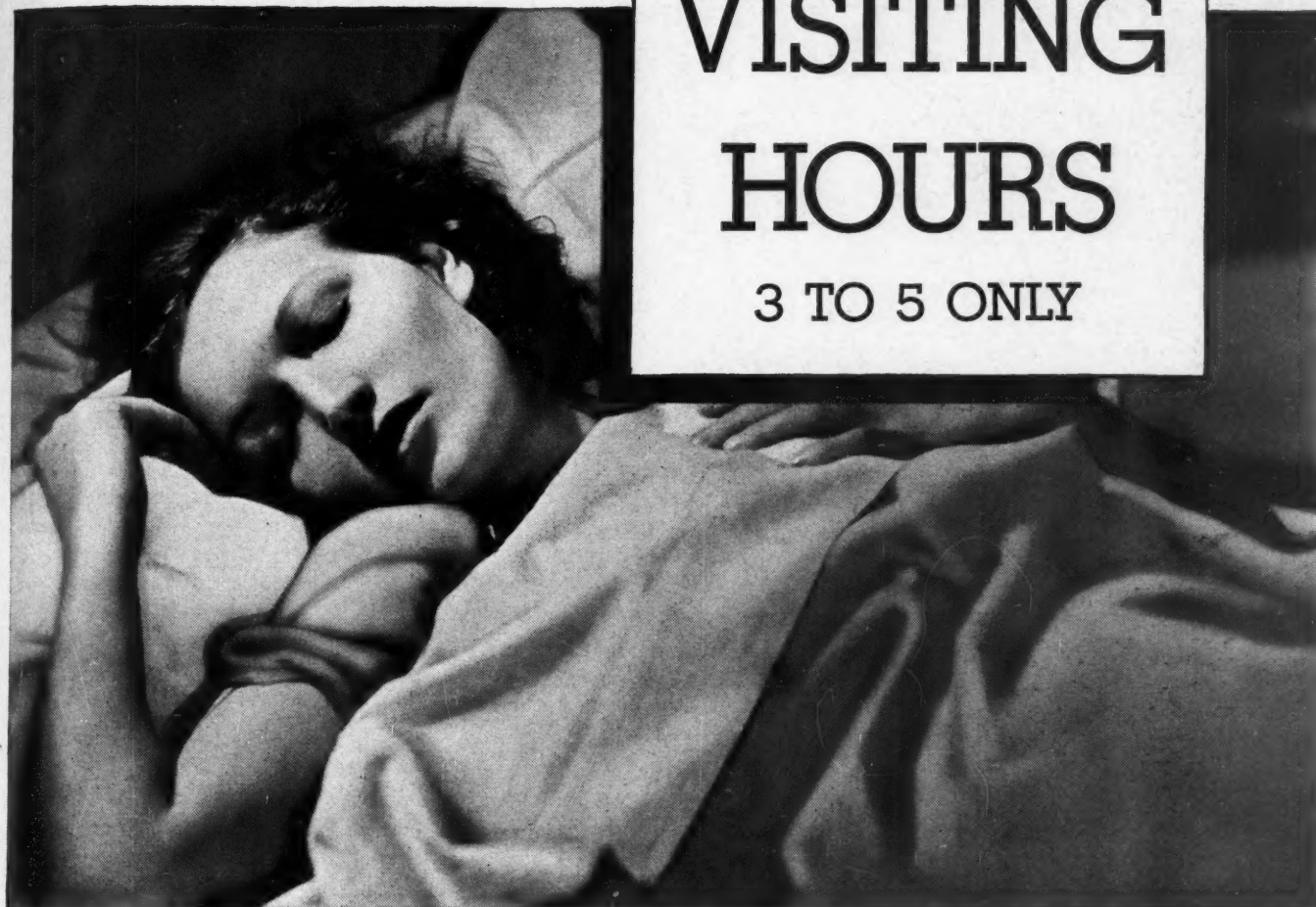
### New Jersey Changes ERA Payments

Two changes have been made in the relief payment for hospital care as paid by the New Jersey state relief council: the first, the payment of a flat rate of \$1.75 per diem for hospital care for ERA clients and the second the payment of an additional fifty cents per day in maternity cases after the birth of the baby.



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## Plans for National Hospital Day Observance Include Many Varied Programs

Nationwide radio broadcasts and intensive local publicity are featuring the advance campaign for National Hospital Day. It is anticipated by the A. H. A. committee that this year's observance should equal or exceed that of any previous year.

Mary M. Roberts, editor, *American Journal of Nursing* and a member of the A. H. A. committee on National Hospital Day, will speak over the Mutual Broadcasting System on May 12 at 1:15 p. m., Eastern Standard Time, on "The Imperishable Glory of Florence Nightingale." This will be carried by WOR, New Jersey; WGN, Chicago; WLW, Cincinnati, and CKLW, Detroit. Arrangements are being made for Clara Noyes, director of nursing, American Red Cross, to speak on a nationwide hook-up from Chicago on the same day.

President and Mrs. Roosevelt have been asked to visit a hospital on National Hospital Day. Presumably they would visit one of the federal hospitals in Washington.

Intensive publicity is being carried on in Chicago where the American Red Cross will be holding its national convention from May 11 to 14. Chicago Lying-In Hospital is scheduling its observance for Sunday, May 10, so that it will coincide with Mothers' Day. Most Chicago hospitals, however, are observing the twelfth. Announcements are being carried in nearly 400 church bulletins in the Chi-

cago area. Mrs. Edna K. Nelson, superintendent, Women's and Children's Hospital, will speak briefly on May 9 over radio station WLS announcing National Hospital Day, and Paul Fesler, superintendent, Wesley Hospital, will speak over the same station on Sunday, May 10. The department stores are arranging special displays and some of them will mention the day in their regular advertisements. Both the governor of the state and the mayor of Chicago are issuing proclamations. It is hoped that announcements can be made in the public schools. Bethany Hospital School of Nursing will hold its graduation exercises on May 12.

At the request of the Chicago committee on National Hospital Day, the Physicians' Record Company, Chicago, has prepared special stationery that may be used by hospitals to invite former patients and others to their institution on National Hospital Day. This stationery includes the picture of Florence Nightingale which was drawn by Howard Cox.

Parke-Davis and Company, as usual have prepared posters and leaflets for National Hospital Day. These are available without charge in any quantities desired and may be had by application to the nearest Parke-Davis representative. They reproduce the advertisements which this firm is running in national periodicals to call attention to the day.

### Convention Favors Plan for Periodic Payments

About 800 hospital executives, nurses, medical social workers, dietitians, and librarians registered for the annual convention of the Association of Western Hospitals, meeting in San Francisco, April 20 to 23, in conjunction with the Western Catholic Hospital Association and the Association of California Hospitals.

All of the addresses and round tables were pointed to the convention theme, that of the evolution of the modern hospital to fit changing conditions, and resulted in the adoption of a resolution urging the development of periodic payment plans to cover hospital care in private institutions. Throughout the convention attention was directed to the constant need for a program of education within the hospital as well as without, in order successfully to combat demands for organized changes in hospital care or against economic schemes for provid-

ing care that have been found inadequate or impossible to operate.

Dr. Glenn Myers, medical director, Compton Sanitarium, Compton, Calif., was chosen president elect of the association. Dr. L. M. Wilber, superintendent, San Francisco Hospital, San Francisco, was installed as president; William P. Butler, superintendent, San Jose Hospital, San Jose, Calif., and J. Howard Jenkins, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah, were installed as vice presidents, and A. C. Jensen, superintendent, Fairmont Hospital, San Leandro, Calif., as treasurer, at the final session of the association.

### Opens New Glass Pavilion

An all-glass ward has been opened as an addition to the children's pavilion, of the Israel Zion Hospital, Brooklyn, N. Y. A terrace surrounds the glass enclosure where convalescents may be moved on warm days.

### N. J. Dietitians Hold Meeting

An unusually interesting program was presented at the bi-annual spring meeting of the New Jersey State Dietetic Association held in April at the Essex Mountain Sanatorium, Verona. Following the business meeting conducted by Asta Low Packard, president, Dr. Byron M. Harman, superintendent, Essex Mountain Sanatorium, discussed the newer trends in the diagnosis and care of tuberculosis. Following a trip through the sanatorium and luncheon, Gladys Poole, psychologist, State Teachers College, Trenton, talked on the psychology of feeding people and Helen Stacey, nutritionist, American Telephone and Telegraph Co., New York, presented a paper on the importance of a nutrition program for industrial groups.

### Plans Progress on Hackensack Building

Plans are rapidly progressing for the new wing which is to be added to the Hackensack Hospital, Hackensack, N. J., and which will completely replace the wooden structure comprising what is known as the "old hospital." The cost of this modernization program will approximate \$250,000. It will not increase the patient capacity of the hospital but in addition to modernizing its facilities throughout, will facilitate future expansion.

### \$3,000,000 for Cancer Hospital

A \$3,000,000 gift from the Rockefeller Board to establish a hospital for cancer research has been announced by Harry Pelham Robbins, president of Memorial Hospital, New York City, the oldest special cancer hospital in the world. The new hospital will be erected on Sixty-seventh Street near the East River and will have accommodations for 200 patients, a modern cancer institute even more broadly organized than those now existing in Rome, Milan and Buenos Aires.

### Psychiatric Workers to Meet

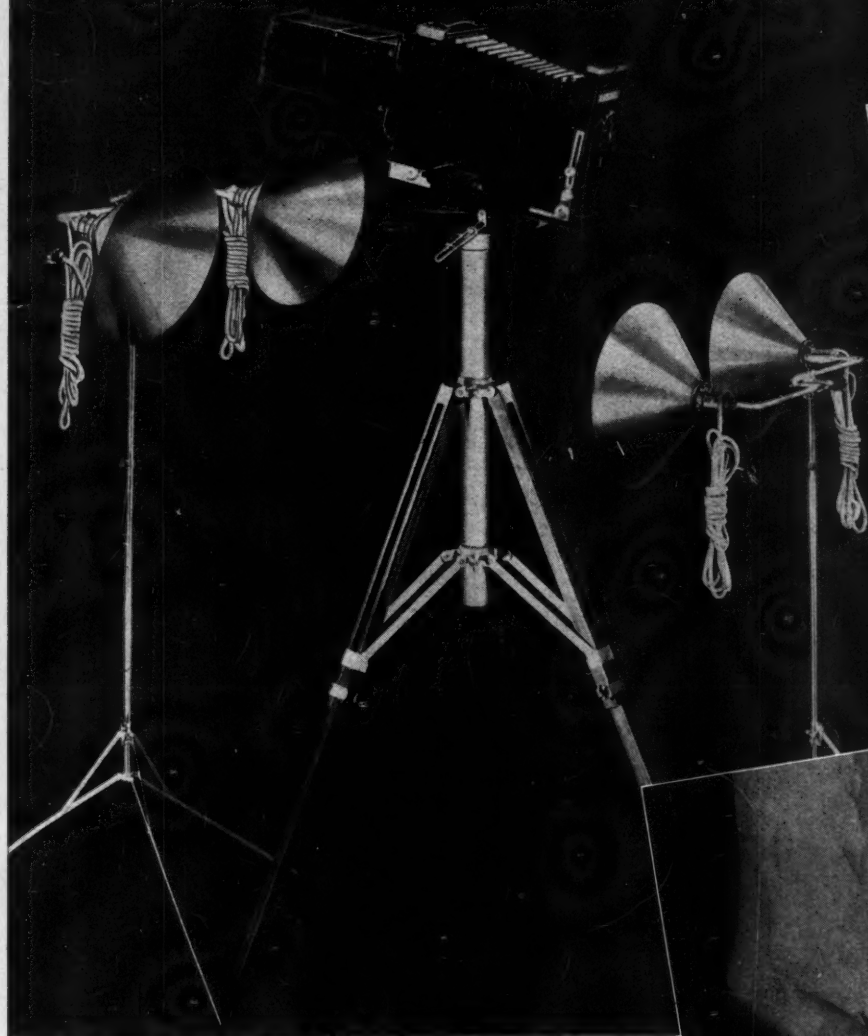
The American Association of Psychiatric Social Workers are holding their spring convention in connection with the National Conference of Social Work at Atlantic City, May 17 to 23.

### Dr. Brush Publishes New Poems

"Hillman" is the title of the third book of poetry written by Dr. Fred-eric Brush, administrator, Burke Foundation for Convalescents, White Plains, N. Y., and published by the David McKay Company, Philadelphia. Doctor Brush's other two books are "The Long Hills," a narrative poem, and "Crooked River."



# Photograph the FACTS

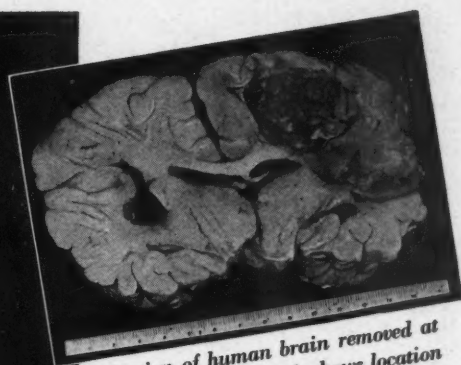


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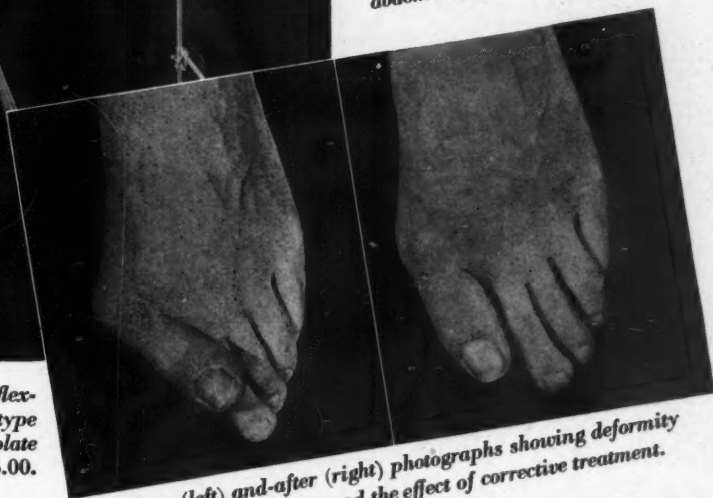
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Section of human brain removed at autopsy. Photograph shows location of lesion and extent of destruction.



Photograph showing extensive area of psoriasis which involved the arms, abdomen, and legs.



Before- (left) and-after (right) photographs showing deformity of foot (hallux valgus), and the effect of corrective treatment.

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## N. Y. Hospital Association Outlines Buffalo Program

An unusual program and an important technical exposition incorporating fifty-eight exhibits of hospital supplies have been planned for the twelfth annual convention of the Hospital Association of New York State to be held at Buffalo, May 21 and 22, concurrently with the conventions of the New York State Dietetic Association, the New York State Association of Nurse Anesthetists and the New York State Association of Medical Record Librarians.

The program committee under the chairmanship of Ernest G. McKay has prepared an interesting and instructive program for the Thursday afternoon and Friday morning and afternoon sessions. Thursday morning will be devoted to the usual business session and will be followed in the afternoon by the round table under the leadership of Dr. R. C. Buerki, president of the American Hospital Association. This round table is an annual feature of the convention. The annual banquet of the association and its allied groups will be held Thursday night. Walter F. Schmieding, an entertainer of national reputation, will be the principal speaker. The banquet will be followed by a floor show.

The Hospital Council of Buffalo will entertain the hospital delegates at luncheon on Friday when Samuel B. Botsford, executive vice-president of the Buffalo Chamber of Commerce, will give the principal address. Saturday morning the local arrangements committee, under the chairmanship of H. A. Grimm, superintendent, Millard Fillmore Hospital, Buffalo, has arranged for a golf tournament to be followed by a trip to Niagara Falls and a tea at the Niagara Falls Memorial Hospital where P. Godfrey Savage, past president of the association, is superintendent.

## To Celebrate Golden Jubilee of First M. E. Hospital

The Golden Jubilee of the beginning of deaconess work and the founding of hospitals, homes for children and homes for the aged will be celebrated at the annual meeting of the National Methodist Hospital Home and Deaconess Association at Columbus, Ohio, May 8 to 10, being held during the quadrennial session of the General Conference, the governing body of the Methodist Episcopal Church.

The first Methodist Hospital in the United States was erected fifty-five years ago in Brooklyn, N. Y., through the generosity of George I. Seney. Seventy-two hospitals have been founded since that first in 1881, and they now represent a property and

endowment value of \$65,000,000.

The group meeting on hospital work will be in charge of Rev. F. G. Fowler, superintendent, White Cross Hospital, Columbus, who is also scheduled to discuss the "Fifty Golden Years of Methodist Hospital Service." Rev. Robert Warner, superintendent, Deaconess Hospital, Spokane, Wash.; Rev. J. P. Van Horn, superintendent, St. Luke's Methodist Hospital, Cedar Rapids, Ia., and Minnie Draher, superintendent of nurses, Bethesda Hospital, Cincinnati, are among the speakers at the group meeting. Bertha E. Beecher, assistant superintendent, Christ Hospital, Cincinnati, and Rev. C. C. Marshall, director, Methodist Episcopal Hospital, Brooklyn, will summarize the convention.

## Critical Analyses to Mark New Jersey Program

The program for the twelfth annual convention of the New Jersey Hospital Association, meeting at Atlantic City, June 4 to 6, has been planned to create mutual interest among members of the Association of Medical Record Librarians of New Jersey, the New Jersey Society of X-Ray Technicians, the New Jersey Occupational Therapy Association, the New Jersey State Dietetic Association, the New Jersey State Nurses' Association and the New Jersey Association of Medical-Social Workers, as well as among members of the hospital group. Two symposiums are scheduled for June 5.

The first symposium is to discuss upon whom the responsibilities for community hospital problems should rest. William A. Paterson, attorney and president, Paterson General Hospital, Paterson, is to represent the trustee; Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., the administrator, and Dr. Spencer T. Snedecor, vice-president, Medical Society of New Jersey, the physician. Charles F. Neergaard, hospital consultant, New York City, will summarize the discussions.

A critical analysis of hospitals today from the standpoint of sociology, mental hygiene, religion, public health, economics and medical science makes up the second symposium. Dr. Francis Brown, assistant professor of sociology, New York University; Dr. Stephen P. Jewett, neuropsychiatrist at New York Medical College; Dr. Lloyd Foster, Calvary Methodist Church, East Orange; Dr. Haven Emerson, Columbia University; William J. Ellis, commissioner, department of institutions and agencies; Dr. Thomas K. Lewis, medical practice committee, Medical Society of New Jersey; and F. Stanley Howe, director, Orange Memorial Hospital, Orange, are the contributors.

## Coming Meetings

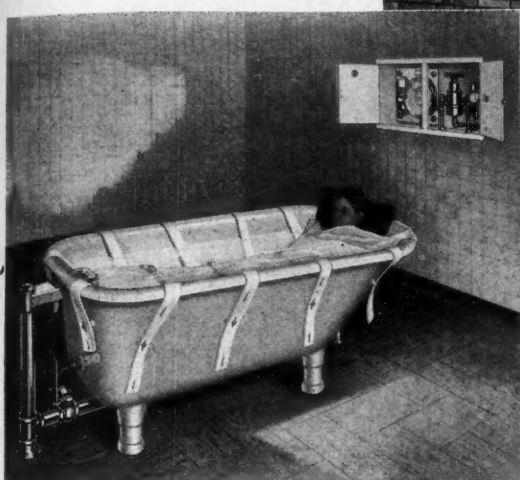
- Washington State Hospital Association.  
Next meeting, Seattle, May 2.
- Mississippi Hospital Association.  
Next meeting, Greenville, May 4.
- Tri-State Hospital Assembly. (Indiana, Illinois, Wisconsin)  
Next meeting, Chicago, May 6-8.
- National Methodist Hospitals and Homes Association.  
Next meeting, Columbus, May 8-10.
- American Medical Association.  
Next meeting, Kansas City, Mo., May 11-15.
- Minnesota Hospital Association.  
Next meeting, St. Paul, May 14-15.
- National Executive Housekeepers Association.  
Next meeting, Chicago, May 15-17.
- Hospital Association of New York State.  
Next meeting, Buffalo, May 21-22.
- American Association of Medical Social Workers.  
Next meeting, Atlantic City, May 24-30.
- National Conference of Social Work.  
Next meeting, Atlantic City, May 24-30.
- Michigan Hospital Association.  
Next meeting, Grand Rapids, May 28-29.
- New Jersey Hospital Association.  
Next meeting, Atlantic City, June 4-6.
- Connecticut Hospital Association.  
Next meeting, Hartford, June 6.
- Catholic Hospital Association.  
Next meeting, Baltimore, June 15-19.
- Three National Nursing Organizations, Biennial Meeting.  
Next meeting, Los Angeles, June 22-27.
- Mid-West Hospital Association.  
Next meeting, St. Louis, June 26-27.
- Missouri State Hospital Association.  
Next meeting, St. Louis, June 26-27.
- Manitoba Hospital Association.  
Next meeting, Winnipeg, June 29-30.
- Institute for Hospital Administrators.  
Next meeting, Chicago, Sept. 9-23.
- American College of Hospital Administrators.  
Next meeting, Cleveland, Sept. 26-28.
- American Protestant Hospital Association.  
Next meeting, Cleveland, Sept. 26-28.
- American Hospital Association.  
Next meeting, Cleveland, Sept. 28-Oct. 2.
- National Association of Nurse Anesthetists.  
Next meeting, Cleveland, Sept. 29-Oct. 1.
- Children's Hospital Association.  
Next meeting, Cleveland, Sept. 30-Oct. 1.
- American Dietetic Association.  
Next meeting, Boston, Oct. 11-16.
- American College of Surgeons.  
Next meeting, Philadelphia, Oct. 19-23.
- Ontario Hospital Association.  
Next meeting, Toronto, Oct. 19-23.
- American Public Health Association.  
Next meeting, New Orleans, Oct. 20-23.

## Denver Council Elects Officers

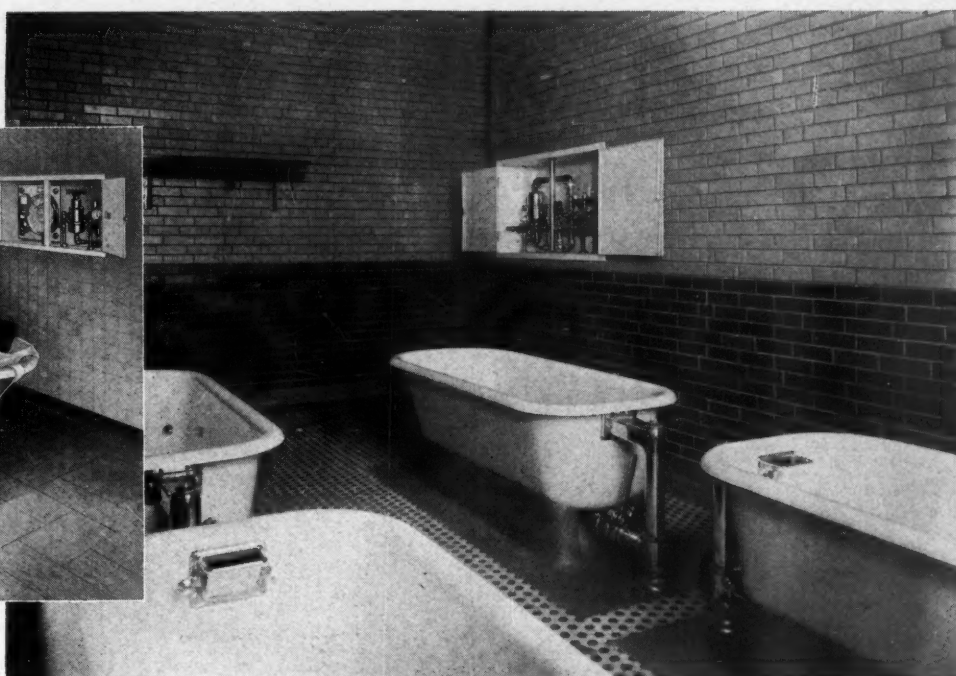
At the third annual meeting of the Denver Hospital Council on March 13 at the Children's Hospital, Denver, the officers of the council who had held office continually since the inception of the organization, declined to hold office longer. William S. McNary, business manager, University of Colorado School of Medicine and Hospitals, was then elected president, the Rev. John R. Mulroy, director of Catholic Charities, Denver, was made first vice president, and Mrs. Oca Cushman, superintendent of Children's Hospital, was chosen secretary-treasurer. The new officers were installed at the regular monthly meeting of the council on April 16 at Mercy Hospital, Denver.



View in Hydrotherapy Department, Manteno State Hospital, Manteno, Illinois



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Vol. 46, No. 5, May, 1936

## NEW BUILDING PROJECTS

LOS ANGELES, CALIF.—The highlight of the celebration of the forty-ninth anniversary of the founding of Occidental College was the ground breaking ceremony for the new Helen G. Emmons Memorial Hospital, to be erected on the campus, a gift of George E. Emmons of Pasadena.

MERCED, CALIF.—A twenty-bed addition is being planned for Mercy Hospital, according to an announcement made by the hospital's directors. The addition is to cost \$30,000.

ST. PETERSBURG, FLA.—Plans for the construction of a fireproof six-story building have been announced by St. Anthony's Hospital, that call for the razing of the present nurses' home, laundry and convent. The new building is to be organized with administrative units that will permit the closing of floors not in use. A large roof garden, an operating suite providing special facilities for nose, throat, orthopedic and urologic surgery, expansive quarters for the x-ray department which will have its equipment increased to six diagnostic outfits, and modernization of the deep therapy department of the institution are among the features of the new building. The present hospital building will be utilized as a convent and nurses' home and for the care of convalescents.

LOUISVILLE, KY.—Construction of a \$446,000 addition to increase the capacity of the Louisville City Hospital by eighty beds was started recently as part of the city's 1936 PWA program.

MINNEAPOLIS, MINN.—As a result of the Minnesota Supreme Court's upholding of a \$350,000 bequest by Oliver C. Wyman to the trustees of the Westminster Presbyterian Church, owners and operators of Abbott Hospital, the hospital now plans the construction of a wing to accommodate 100 patients and to be known as the Wyman Pavilion. . . . Construction will be started this month on the Whitney Memorial Building, a five-story addition to St. Barnabas Hospital. Of fireproof construction, air conditioned and acoustically treated, the addition is expected to cost \$150,000. Hewitt and Brown are the architects who designed the building, and their plans include admission and business offices, reception rooms, physicians' lounge, first aid quarters and laboratories on the first floor; single rooms on the second and third floors; obstetric quarters, nursery, examining and isolation room and husbands' lounge on the fourth, and surgical units on the fifth.

HOT SPRINGS, N. M.—Ground was broken recently for construction of a new hospital for crippled children to cost \$400,000. With the exception of one building, the hospital will be but one story high. It will have accommodations for eighty-four and an outdoor swimming pool connected with an indoor treatment pool.

MOUNT MORRIS, N. Y.—The new Mount Morris Tuberculosis Hospital received its first three patients in March, though it had not yet been formally opened. The recently completed main building is Georgian in architecture and the auxiliary buildings colonial. The unit provides accommodations for 200 adult patients and the children's building, which is still under construction, will accommodate 50 patients.

NEW YORK, N. Y.—The Missionary Sisters of the Sacred Heart, operators of Columbus Hospital and Columbus Hospital Extension, are now constructing a third hospital to be known as the Mother Cabrini Memorial Building. Erected next to the Extension, the building is to be Italian in architecture and stand in the center of a landscaped plot of ground that will have a sunken garden. The structure is to cost \$175,000 and will provide accommodations for 100 beds.

MEMPHIS, TENN.—Three new buildings are being planned for the historic United States Marine Hospital, a nurses' home, a hospital addition to accommodate 100 patients and a home for the medical staff. The main building will be three stories, with offices on the first floor and wards on the second and third. This building will connect with the newly finished surgical and laundry unit. The present office building will be torn down. The nurses' home is to be two stories high, with a recreation room in the basement, and reception rooms, bedrooms, kitchens and community rooms on the first and second floors. The junior medical officers' quarters will also be two stories high. The three buildings will be colonial in architecture.

ABILENE, TEX.—A four-story wing is being added to the east end of the West Texas Baptist Sanitarium that will provide fifty-four beds. Each floor of the addition is to be equipped with thermostatic heat control to be regulated by the nurse in charge.

LONGVIEW, WASH.—A one-story fireproof addition is about to be constructed at the Cowlitz General Hospital to include private rooms, wards for twenty beds, a large nursery and other facilities.

### Ten Year Building Program

A list of recommendations for improvements that he feels should be made at hospitals under the jurisdiction of the City of New York department of hospitals within the next ten years was recently compiled and submitted to the city planning commission by Dr. S. S. Goldwater, commissioner of hospitals. The improvements suggested total \$53,300,000 and are divided among three groups, those included in the approved budget for 1936, those to be begun during the next five years and those for initiation after 1941. The new Research Hospital for Chronic Disease, Welfare Island, is included in the 1936 budget.

### Caldwell Hospital Reorganized

National Hospital Day will probably see the reopening of the Caldwell General Hospital, Caldwell, Kans., in its new home, the remodeled Glover Hotel, where it will have accommodations for eighteen patients with a possible expansion to twenty-five. A board of trustees was recently organized for the management of the institution, and a state charter for their operation as the Caldwell General Hospital Association has been applied for. Paul Baker, a Kansas City architect, has designed the remodeling program which will provide for four doctors' offices on the first floor, the hospital proper on the second, and a nurses' home and superintendent's apartment on the third. Nine individuals and firms are furnishing a room apiece in the new building.

### Kilgore Hospital Completed

The Kilgore Memorial Hospital, erected and furnished in memory of the settlers of Kilgore, Tex., held open house for two days upon its completion. The building includes nine private patient rooms for white persons and one for colored; two three-bed and one two-bed wards for whites; one three-bed ward for colored; besides operating, obstetric, emergency and x-ray rooms. Five of the private rooms and the operating room were entirely equipped by prominent persons of Kilgore. Doska J. Crawford, R.N., has been made superintendent of the institution, which is operated by Dr. J. E. Adams and Dr. D. C. Simmons.

### Closed Hospital Is Reopened

Mrs. Myra H. Noyes, R.N., is reopening the Snoqualmie Falls Hospital, Snoqualmie Falls, Wash., which has been closed for three years. The institution has accommodations for fifty patients and is the only hospital in the town.





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# NAMES IN THE NEWS...

DR. MORRIS HINENBURG, assistant director at Montefiore Hospital for Chronic Diseases, New York City, who had planned to study the problem of chronic disease in Europe this summer, has canceled his plans in order to accept the office of superintendent of the Jewish Hospital, Brooklyn, N. Y., on May 1. Doctor Hinenburg is being succeeded at Montefiore by DR. JACK MASUR, resident physician at Montefiore who has just returned from Amsterdam where he had been studying under Professor Snapper on a Montefiore scholarship.

DR. ALBERT M. BARRETT, organizer of the University of Michigan Hospital for Treatment of Mental Diseases, Ann Arbor, and head of that institution since 1906, died at the age of sixty-four years. Doctor Barrett at one time served as head of psychiatric institutions in Massachusetts.

RAYMOND F. HOSFORD, superintendent of Bradford Hospital, Bradford, Pa., was recently elected president of the Northwestern Section of the Hospital Association of Pennsylvania.

MARIAN A. BATDORF, superintendent of Wyoming Valley Homeopathic Hospital, Wilkes Barre, Pa., resigned from that position on April 1.

DR. SETH F. H. HOWES, assistant superintendent of the Rhode Island State Infirmary, Howard, has been appointed superintendent of the institution to succeed DR. KARL B. STURGIS.

DR. THOMAS W. HAGERTY, chief surgeon and psychiatrist at the Stockton State Hospital, Stockton, Calif., has been appointed superintendent of the newly opened 1,200-bed Camarillo State Hospital, Camarillo, Calif.

LUCILE MULLEN, Parkland Hospital, Dallas, Tex., is the new superintendent of the King's Daughters' Hospital, Brookhaven, Miss.

DR. G. LOMBARD KELLY, dean of the University of Georgia School of Medicine, has been named superintendent of University Hospital, Augusta, Ga., through an ordinance adopted by the city council preparing the way for the new dual system of administration recently created by the institution's board of trustees. The measure provides that the superintendent shall be dean of the University of Georgia School of Medicine.

BETTYE BARGO has been appointed superintendent of nurses at the Som-

erset General Hospital, Somerset, Ky., to succeed the late LUCY DUTTON.

DR. RAYMOND B. ALLEN, associate dean of Columbia University Medical School and associate director of the New York Post Graduate Medical School and Hospital, has been appointed dean of the college of medicine of Wayne University, Detroit.

ADELAIDE MAYO, who was a member of the nursing education staff during the 1935 summer session at Teachers College, Columbia University, has been appointed director of the recently established school of nursing at Russell Sage College, Troy, N. Y.

DR. IRA A. DARLING, formerly superintendent of Warren State Hospital, Warren, Pa., has been appointed superintendent of Springfield State Hospital, Sykesville, Md.

DR. ROBERT F. BERRY has been appointed superintendent of Morgan Heights Sanatorium, Marquette, Mich.

DR. J. H. SENN has been appointed superintendent of the mental hospital recently opened at Lakehead, Ont., to replace the former Fort William Industrial Farm. AGNES BAILLIE is the new superintendent of nurses.

DR. DEAN HUGH MINNIS has been made superintendent of Pleasant View Sanatorium, Amherst, Ohio, where he succeeds DR. A. H. SMITH.

CAMILLA FULPER, assistant directress of nurses at Scranton State Hospital, Scranton, Pa., has been appointed to succeed IDA GALEY as directress.

DR. CHARLES ZELLER, assistant superintendent of the Farview State Hospital, Waymart, Pa., who was recently appointed superintendent of the Veterans' Administration Facility, Portland, Ore., will remain at Farview and succeed DR. CLARK C. HOLBROOK, superintendent.

CAROLYN B. SYKES, superintendent of the Southside Community Hospital, Farmville, Va., has announced her resignation to be effective July 1.

MARGARET KLOETFER had been appointed to succeed MRS. FLORENCE DOAN as matron of the Nye County Hospital, Tonopah, Nev.

TEUNIS J. VAN DER BENT, member of the architectural firm of McKim, Mead & White, New York City, died at the age of seventy-three. Mr. van der Bent was well known to the hospital field through his association for thirty

years with the Bellevue Hospital building program. Among other projects in which he participated were the Gouverneur Hospital, New York City, and Burke Foundation, White Plains, N. Y.

DR. A. W. CHANDLER, founder of Lincoln Hospital, Rochelle, Ill., and its director for many years, died at his home in Rockford, Ill., at the age of seventy-five.

MRS. ALICE C. CLELAND, formerly superintendent of Mount Sinai Hospital, Hartford, Conn., has been appointed superintendent of New Hampshire Memorial Hospital, Concord, N. H., to succeed MAUD A. MILES who resigned.

DR. CHARLES E. VAIL, head of the American Presbyterian Hospital and its medical school at Miraj, Bombay Presidency, India, died there at the age of fifty-five. Ten years ago Doctor Vail was decorated by the late King George V of England for medical services in that country.

DR. HARRY C. HOFFMAN, superintendent of the Somerset County Home and Hospital, Somerset, Pa., has been replaced by DR. C. I. SHAFFER, deputy county coroner.

MRS. LOLA CEASE, for many years superintendent of Ahwahnee Sanatorium, Ahwahnee, Calif., who was asked to retire by the hospital directors, was rehired after a stormy battle between the supervisors from Madera, Merced and Stanislaus Counties. C. LOUIS WOOD, a relative of one of the directors, who had been appointed to succeed Mrs. Cease, resigned from the position he had never actually held.

SOPHIA PIEFER is the new superintendent of the Murphy Memorial Hospital, Red Oak, Ia.

LILY B. WELLS has been appointed superintendent of the Walker County Hospital, Jasper, Ala., where she succeeds GERTRUDE T. HAYNES.

MARY L. LAIBE, R. N., has been made the new superintendent at Northwestern Hospital, Des Plaines, Ill.

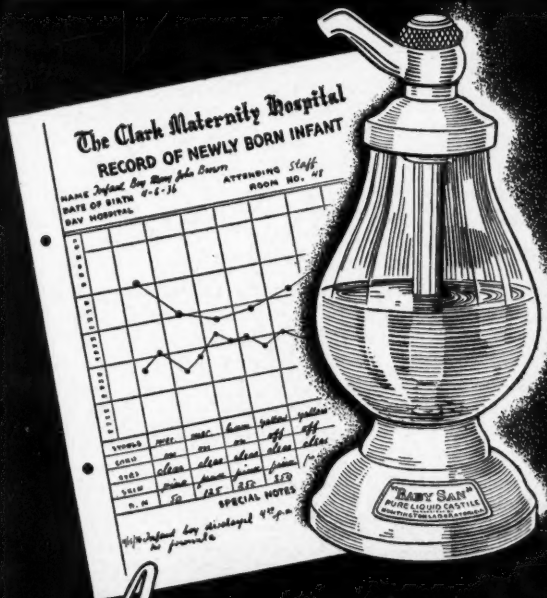
MRS. STELLA H. AMASS has been appointed state director of psychiatric education by the board of control of public institutions in the State of Minnesota. She has been educational director at Kankakee State Hospital, Kankakee, Ill., Menninger Sanitarium, Topeka, Kan., and Fergus Falls State Hospital, Fergus Falls, Minn.

NAOMI KERSAW, supervisor in charge of the laboratory and bacteriologic departments of the Holy Cross Hospital, Salt Lake City, Utah, has been appointed superintendent of the Cottage Hospital, Burley, Idaho.



# BABY-SAN

AMERICA'S FAVORITE BABY SOAP



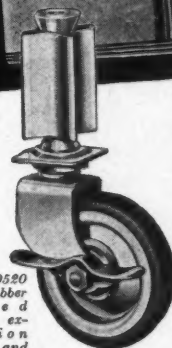
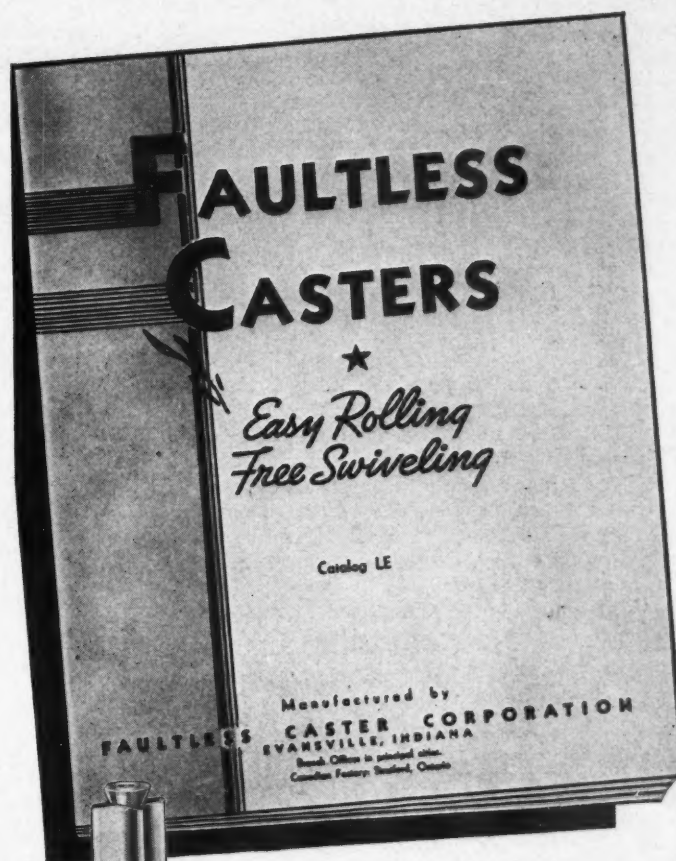
## Assurance OF STEADY PROGRESS

From the very moment of the baby's birth, Baby-San—purest liquid castile soap—contributes to the infant's health. It gently removes the vernix and all dangerous surface bacteria. In the daily bath, it cleanses . . . leaves a film of olive oil to guard against dryness and to help maintain body temperature.

No other soap keeps the baby's skin so healthy. That's why Baby-San—dispensed from the Baby-San Dispenser\* is the choice of 75% of the nation's nurseries.

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# FAULTLESS CASTERS

DR. L. O. WELDON has been appointed superintendent of the United States Marine Hospital, New York City, to fill the vacancy caused by the death of the late ALBERT J. BEEKMAN.

CAROLYN DAVIS, executive head of the Good Samaritan Hospital, Portland, Ore., has resigned from that position and will take a trip abroad. DR. CHARLES H. MANLOVE, a member of the staff of the hospital, has been appointed acting superintendent.

GEORGE H. BUCK, administrative intern at Massachusetts General Hospital, Boston, following his graduation from the University of Chicago course in hospital administration, has been made assistant to JOHN H. HAYES, superintendent of Lenox Hill Hospital, New York City. He fills the post left vacant by the appointment of J. WILSON KELLER as superintendent of Lawrence Hospital, Bronxville, N. Y.

NELLIE ORR, R.N., superintendent of nurses at the Philadelphia Hospital for Mental Diseases, Byberry, Philadelphia, a position she has held for many years, resigned during April.

J. MARIE MELGAARD, director of the dietary department, Mount Sinai Hospital, Philadelphia, resigned from that position to return to her home in Minnesota for a rest. Miss Melgaard has been with the hospital for eleven years.

F. R. CADDY, formerly assistant accountant, Medical Arts Center, New York City, has been made assistant superintendent of St. Luke's Hospital, New York City.

MONTEZ WAYNE, superintendent of Petersburg Hospital, Petersburg, Va., for six years, resigned from that post. HARRIET PATTERSON, instructor of nurses, has been appointed acting superintendent.

#### Dr. Doane to Give Lecture Course

Dr. J. C. Doane, editor of *The Modern Hospital* and medical director of Jewish Hospital, Philadelphia, is to conduct a two weeks' refreshment course for institutional executives at Cornell University, Ithaca, N. Y., from June 29 to July 11. The course will be carried out on the lecture conference plan.

Other courses of interest to the hospital field are being given just before and just after Doctor Doane's. A one-week unit course in personnel management is scheduled for the week of June 22 and a course in housekeeping and another in menu planning are being held the week of July 13. There are no formal entrance requirements for these courses, but admission is limited to those who are or have been actively engaged in hospital or hotel work.

## Pennsylvania Hospital Administrators

### Consider "Three Cents a Day Plan"

Group hospitalization or "The Three Cents a Day Plan" was the major subject of discussion during the sessions of the Hospital Association of Pennsylvania held in Pittsburgh, April 22 to 24. It was explained to the delegates, some one thousand in all, by Frank Van Dyk, executive director of the Associated Hospital Service of New York. The system involves neither charity nor profit, according to Mr. Van Dyk. "Our rapidly growing enrollment," he said, "has been accomplished mainly as the result of public education and not as the result of direct solicitation." A soundly administered plan in Pittsburgh and other Pennsylvania cities should grow rapidly, assuming, of course, that all of the hospitals participate in offering the service."

#### Urges Group Plans Throughout State

Dr. Samuel Haythorne, Allegheny General Hospital, presented an excellent paper on "Group Hospitalization as the Doctor Sees It." As chairman of a committee of the Allegheny County Medical Society to investigate all phases of group hospitalization plans, he gave an impartial presentation of the various advantages and disadvantages from the standpoint of the medical profession. Dr. Donald C. Smelzer, director, Graduate Hospital of the University of Pennsylvania, Philadelphia, discussing both papers, expressed the opinion that there were no sound objections presented by the medical profession and urged the starting of such plans throughout the state.

The three-day convention covered many more phases of hospitalization. Practically every phase of administration was included in the programs arranged by John N. Hatfield, executive secretary of the association and superintendent of the Pennsylvania Hospital, Philadelphia, and his efficient staff. Accompanying sessions of the Pennsylvania Association of Nurse Anesthetists also contributed a divergence of interest and brought many visitors who in addition to participating in the meeting inspected carefully the exhibits of hospital equipment and surgical appliances shown by some sixty-one manufacturers.

Each year the Pennsylvania association devotes one session of its annual meeting to hospital trustees. This year the problem of creation and management of endowment and special funds was discussed by Gwilym A. Price, People's Pittsburgh Trust Company, William A. Wilson, attorney of Pittsburgh, and H. Parker, Standard Statistics Company. H. L. Mason, Jr.,

vice president of the board of Allegheny General Hospital, Pittsburgh, presided.

The nursing situation, always the center of much interest, was referred to by Pres. J. Allen Jackson, superintendent, Danville State Hospital, Danville, in his opening address. Denying that hospitals are using student nurses as "glorified hospital maids," Doctor Jackson urged a reduction in the cost of training nurses. If hospitals continue to be asked to meet the expanding requirements of educators and the federal and state governments, without financial aid, he pictured the following situation prevailing in smaller institutions: "Possibly a few graduate nurses, milk-maids and farm boys from the country will be enlisted as nursing attendants, orderlies and helpers to care for the sick. Gradually these will be given a course of attendant training only to graduate and enter the community in competition with the highly educated nurse. Many of these will be employed by the rank and file of people who are unable to pay the highly trained nurse an adequate wage commensurate with the cost of her training."

Of particular interest to members of the Association of Nurse Anesthetists were Doctor Jackson's remarks on the use of suggestion in modern surgery in combination with chemically induced anesthesia. He deplored the neglect of psychologic factors and declared that the older principle of "mind over matter" has given way to chemicals over mind in the treatment of patients undergoing operations. "I am inclined to believe," he said, "that if we had combined the two principles, much apprehension, fright, shock and death might have been avoided. While I have no thought of suggesting a return to hypnotism as a form of anesthesia, I feel that the broad principles of suggestion are very helpful in establishing in the patient a confidence in the hospital, its physicians, its nurses and in the surgeon."

Succeeding Doctor Jackson, J. Melvin L. Sutley, superintendent, Delaware County Hospital, Drexel Hill, becomes president of the association. Mary B. Miller, Presbyterian Hospital, Pittsburgh, was chosen president-elect.

#### Pennsylvania Dietitians to Meet

The Pennsylvania State Dietetic Association is meeting at State College on May 14 and 15 for its annual convention. Jean Hood is chairman of the program committee and Phyllis K. Sprague is in charge of publicity and hospitality.



# Out of the Sterilizer onto the Hand

## ... *Alive and Elastic!*

**A** GAIN and again Seamless Standard Surgeons' Gloves go to the sterilizer and come back to duty alive and elastic. Whether you buy the Latex or the Brown-milled, these gloves give extra wear—longer service.

The staff will like their skin-like fineness and their anatomical fit. The gloves are tissue-thin. And

absolutely uniform! There are no "spots"—not even a drip mark at the finger tips. The surgeon's touch is virtually gloveless.

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All Seamless Standard Surgeons' Gloves are identified by this characteristic seal which appears on the wrist of the glove and on the box.



More than 100,000 Physicians and Surgeons see this advertising every month in the Journal of the American Medical Association, Surgery, Gynecology & Obstetrics, American Journal of Surgery and Annals of Surgery.

Do your patients talk *this way* after hospitalization?

# READER OPINION . . . .

## Unsolicited Criticism

Sirs:

The board of directors of St. Mary's Hospital are making a public appeal to permit the hospital to continue its services in aid of the sick poor. . . . As one of those with whom the hospital is doing business, we felt your firm would like to have a part in contributing towards this most worthy charity. . . .

T. TAGGART SMYTH,  
President.

St. Mary's Hospital,  
Montreal, Que.

To this form letter, The MODERN HOSPITAL replied, in accordance with oft expressed principles, that it believes "it is unethical and an improper business practice for hospitals to appeal for funds to those organizations with which they are doing business, particularly when such organizations are in a different community. The only results of such an appeal can be either (1) the disruption of friendly and advantageous financial relations or (2) placing the hospital in debt to the organization that contributes, thus inhibiting the hospital's freedom of purchase."

The following is Mr. Smyth's reply: ". . . Whilst you are the only judge as to what you can or cannot do, you, of all people, should know that it is only by public subscriptions and endowments that hospitals are maintained. Your good wishes for the success of our efforts would have been more acceptable than your unsolicited and undesirable criticism."—ED.

## Dismal Report

Sirs:

Here is a choice letter which we received in answer to a collection letter sent out by the hospital:

Dear Sirs:

Your inquiry about the matter of Vassar Brothers Hospital vs. Murley Reddy received. I wrote him on receipt of bill, but have heard nothing from him. I did not expect to when I wrote. He is a poor specimen of humanity. He preaches at Pang Yang and wouldn't do any manual labor if he could save the whole world from perdition. I asked one of his parishioners one day what kind of a preacher he was. "Well," he says, "I'll tell you. He ain't got the power of thought—he overpeaks himself." We got a good many of that kind in this country. Am sorry to have to make such a dismal report, but have to be truthful. . . .

J. J. WEBER,  
Superintendent.

Vassar Brothers Hospital,  
Poughkeepsie, N. Y.

## Nursing in Toledo (Con't)

Sirs:

In a communication from (Mrs.) Elizabeth P. August, General Secretary, Ohio State Nurses' Association, appearing in the February issue . . . the Hospital Council of Toledo wishes to call attention to the inaccuracy of some of the statements, namely:

The capacity of Toledo Hospital is 275 beds (including bassinets). As the hospital has never been entirely furnished it contains, at present, 192 beds, including bassinets, instead of 350. The occupancy during 1934-35, the same hospital, was 80 instead of 69, as stated in the article.

The superintendents of the hospitals of Toledo have no knowledge of requesting free service from registered nurses or other members of their personnel.

Regarding all salaries paid to the superintendents of the hospitals—they received equal or greater percentage decreases in salaries than any group or member of the personnel of their respective hospitals.

The members of the Hospital Council of Toledo acknowledge that the hospitals have suffered both financially and in decreased occupancy as much as or more than most communities, but when statements are published they should be founded on facts.

MARY E. YAGER,  
Secretary.

Hospital Council of Toledo,  
Toledo, Ohio.

## Business Survey of Hospitals

Sirs:

Thank you very much for the copy of your March issue . . . containing an editorial on "The Business Survey of Hospitals." This will be of great assistance to us . . . as we have had inquiries as to whether this was just another survey. We have made an effort to prevent having any additional surveys of this nature made by other branches of the federal government.

L. R. THOMPSON,  
Assistant Surgeon General.

U. S. Public Health Service,  
Washington, D. C.

## Costs of Hospital Care

Sirs:

. . . I would like to know the average per capita cost of hospitalization in general hospitals of some city, state or the country as a whole. . . .

M. F. BROOK, M.D.

Grandy Sanatorium,  
Norfolk, Va.

The American Medical Association reports that in 1935 the average daily census of all general hospitals in the United States was 261,294 patients. Multiplying this by 365 gives a total patient days of 95,372,310. The Bureau of the Census estimated the population of the United States in 1935 as 126,416,000 which would give an average of 0.754 hospital days in general hospitals per person per year. The cost of one day's care for one patient in a general hospital ranges from \$2 to \$7, a fair average probably being in the neighborhood of \$3 or \$3.50. This would give average costs per capita per year for general hospital service only of \$2.25 to \$2.65. An indication of the variation in per capita costs is shown in the figures on pages 198 and 199 of the fourteenth edition of The HOSPITAL YEARBOOK.—ED.

## Agonies of the Damned

Sirs:

Many thanks for your offer. I regret that I do not care to take The YEARBOOK. This position, which to you will seem peculiar, is due partly to the fact that I subscribe to so many architectural publications that we never have time to make the proper use of them, and partly to the fact that I have recently had a good deal of experience with hospitals, as I came back from a South American cruise with some hellish infection of the feet. I spent one whole month in one hospital, where

they diagnosed me as a victim of the gout, and then afterwards three weeks in another hospital, where they said there was not the slightest indication of any gout. Here they put me under observation and were unable to find anything the matter with me.

It was such a dreadful experience and the very stupidity of the whole performance has disgusted me to such an extent that I hope I shall never have any more to do with hospitals. I certainly do not wish to be reminded of this experience.

I may say that at the last hospital I had the most expensive room in the place and it was just as uncomfortable and badly planned as it was possible to conceive of. The hospital had been built nine years and I hate to think of the number of unfortunate patients who have been suffering the agonies of the damned apparently without making any protest, as all of them could have been avoided and most of the errors could have been corrected at a minimum cost.

M. T. REYNOLDS,  
Architect.

Albany, N. Y.

## Would Administrators Appreciate?

Sirs:

. . . In view of the value of Mr. Laferriere's articles (on pest and rodent extermination) to administrators as well as to housekeepers, I am wondering whether it would not be worthwhile to consider publishing this series in pamphlet form.

JOHN R. MANNIX,  
Assistant Director.

University Hospitals,  
Cleveland.

Would other administrators agree, if pamphlets are provided at cost?—ED.

## Negro National Hospital Fund (Con't)

Sirs:

. . . A great many people have been deceived because of the obviously worthy objectives. . . . Unfortunately this high purpose has been tied in by Rev. Carnegie with a visionary, unsound and impracticable plan which not only has been condemned by responsible and informed leaders among the Negro medical profession but which is fraught with great danger of misleading well intentioned people of the other race. . . . A great many people write me because he used my name freely in quoting my attitude towards hospitalization for Negroes. This is done very often in such a way as to lead people to believe that the plan has my endorsement. . . .

PETER MARSHALL MURRAY, M.D.  
New York City.

## Free Treatment for Tuberculous

The treatment of tuberculous patients without charge has been proposed by the legislature of Alberta, Canada. If the bill is passed, the government budget will set aside \$280,000 a year for this work, \$100,000 to be a grant to hospitals to increase their accommodations for the tuberculous, the rest to be used for the operation of the Central Alberta Sanatorium, Calgary. At the present time the provincial sanatorium is supported in part by charges to municipalities at the rate of \$1.50 per day and charges to patients, with the balance met by the government. Operating costs are \$2.44 per patient per day, making the deficit to the government \$0.94 per patient day. The item of \$96,000, representing the charges to municipalities and patients will be absorbed by the government and paid by the public in the form of a general tax, according to the proposal.



# Do your patients talk *this way* after hospitalization?



## Patient good-will is just one more reason why IT PAYS TO PROVIDE PALMOLIVE!

*Maybe it will pay you to check up on this so important little detail*

PERHAPS you have thought that since all soaps remove dirt, they are all about the same.

But just consider this. There is one soap that more people prefer... *buy*... than any other. It is the soap that's made with *olive oil*: PALMOLIVE.

*What accounts for this preference?* Well, Palmolive lathers richly in hard

or soft water, hot or cold. It cleanses thoroughly yet gently. It's a mild, *vegetable oil* soap. Its creamy lather soothes tender, fever-dried skin. It is freshly, naturally fragrant.

Because Palmolive is hard-milled... free from air bubbles... it lasts extra-long. And yet Palmolive *costs no more* than many less-favored brands. Why not standardize on Palmolive! Your C. P. P. representative will gladly quote prices on the size you use. Or, write to COLGATE-PALMOLIVE-PEET CO., Jersey City, N. J.



PALMOLIVE SOAP is a pure *vegetable oil* soap, made only from select olive and palm oils.

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# PALMOLIVE

*The Soap that's Made with Olive Oil—the Soap Most People Prefer*

# LITERATURE in ABSTRACT . . .

Conducted by E. M. Bluestone, M.D.

## Disinfecting Dishes Through Careful Washing

Saliva-borne infections as a group are responsible either directly or indirectly for from 25 to 45 per cent of our mortality.\* By laboratory procedures it was shown that 99 per cent of the organisms are removed by the machine method of washing, 78 per cent by hand washing.

The spoon, because of its large exposed surface area, carries more oral bacteria in the mucus adhering to it than any other utensil. Its bacterial load can be determined more easily than that of other utensils. The multiple spoon test for determining cleanliness and disinfection as the standard for all table utensils is simple, accurate and dependable. Another test is the bacterial count per c.c. of wash water. Both of these control factors are important as regulatory factors for the protection of public health.

The need for a higher standard of eating utensil sanitation in public eating places was shown by a recent finding that 33 per cent of the organisms remain on utensils after they are washed. This percentage represents a cross-section of forty-six different restaurants including both the better and poorer types.

If by the soapy water washing method dishes are to be disinfected by either machine or hand washing, they must be subjected to a scalding rinse. In eating places using mechanical washers where there is insufficient scalding water, the disinfection results are greatly improved by the use of an inorganic chlorine preparation in the rinse water. In washing dishes by hand a procedure is presented using a sink of three compartments, two of which contain chlorine.

Low bacterial count must be maintained in the wash water, thus securing better disinfection.

\*Cumming, J. G., M.D., and Yongue, P. H. and N. E.: Eating Utensil Sanitation, *Am. J. Pub. Health*, 26:237, 1936.

## Oropharyngeal Method of Oxygen Therapy

In the State of Wisconsin General Hospital, Madison, the oropharyngeal insufflation of oxygen\* is employed in preference to other methods when oxygen therapy is required. Commercial U. S. P. oxygen in large tanks is used. In order to eliminate waste of oxygen and unnecessary cylinder han-

dling, a central depot was established and the oxygen piped throughout the building into some 58 rooms with 108 bed outlets. In addition, the basal metabolism room and operating room were connected with the system for economy.

The oxygen pipe is connected to a humidifier—a water bottle which breaks up the oxygen into fine bubbles. A soft rubber catheter is connected by large bore tubing to the patient and the humidifier. The catheter is well lubricated with vaseline and inserted through the nose into the pharynx. The depth to which it is inserted is determined approximately by the distance between the external nares and the tragus of the ear, measured off on the catheter. Advantage is taken of the natural "droop" of the catheter to allow the end to hang freely in the pharynx. Its depth is finally adjusted to the patient's comfort so that the oxygen is breathed and not swallowed. It is then taped in position.

Removal of the catheter and replacement by a clean one in the opposite nostril is done at least every twelve to twenty-four hours depending on the amount of accumulated mucus. The rate of flow is started at six to ten liters per minute, according to the patient's needs. The pulse is recorded every fifteen minutes at first and the flow cut down when the maximum reduction in pulse rate has been obtained. By following the patient's clinical condition the amount of oxygen required may be regulated to avoid waste and also gradually to wean the patient from the therapy.

\*Buerki, R. C.: Organization and Administration of an Oxygen Therapy Service in a General Hospital, *Bull. Am. Coll. Surg.*, 21:14 (Mar.) 1936. Abstracted by Leonard Tarr, M.D.

## Guiding and Supervising the Intern

The internship and residency are pivotal factors in the scheme of modern medical education.\* Nevertheless, the training furnished house staffs is often not as effective as it might be. During the first few months of his service the intern is eager for instruction, has not become fixed in bad habits and can be moulded to sustain high standards. During this most critical period of his entire house staff experience, he is in urgent need of active guidance and careful supervision. These are dependent on a number of factors, a few of which are:

1. Preparation of manuals specifying the basic essentials for adequate care of the patient.

2. Teaching of standard nursing procedures—such practical and homely matters as how to make a patient comfortable in bed, how to prepare and apply a mustard paste and how to make up and give various types of enemas.

3. Holding of regular, separate departmental conferences, in which residents and interns take an active part.

4. Definite provision for supervised dispensary and follow-up clinic work.

5. Maintenance of adequate libraries, with full time librarians whenever possible.

6. Adjustment of the proportion of interns to patients, with reasonable case loads.

7. Proper consideration during the internship of the future needs of the intern when he goes into practice.

8. Holding of formal lectures or weekly seminars dealing with problems encountered in the hospital.

9. Provision of larger attending staffs interested in teaching.

Our hospitals must face the need of a more adequate basic internship. Most of the one year rotating internships are insufficient for modern needs. "In the last analysis, by setting high standards for our interns and living up to them ourselves, the fundamentals of an adequate teaching program are achieved," the author states.

\*Curran, J. A.: Function of the Hospital in the Training of Interns and Residents, *J. A. M. A.*, 106:753 (March 7) 1936. Abstracted by J. Marmor, M.D.

## Effect of Food Refrigeration on Public Health

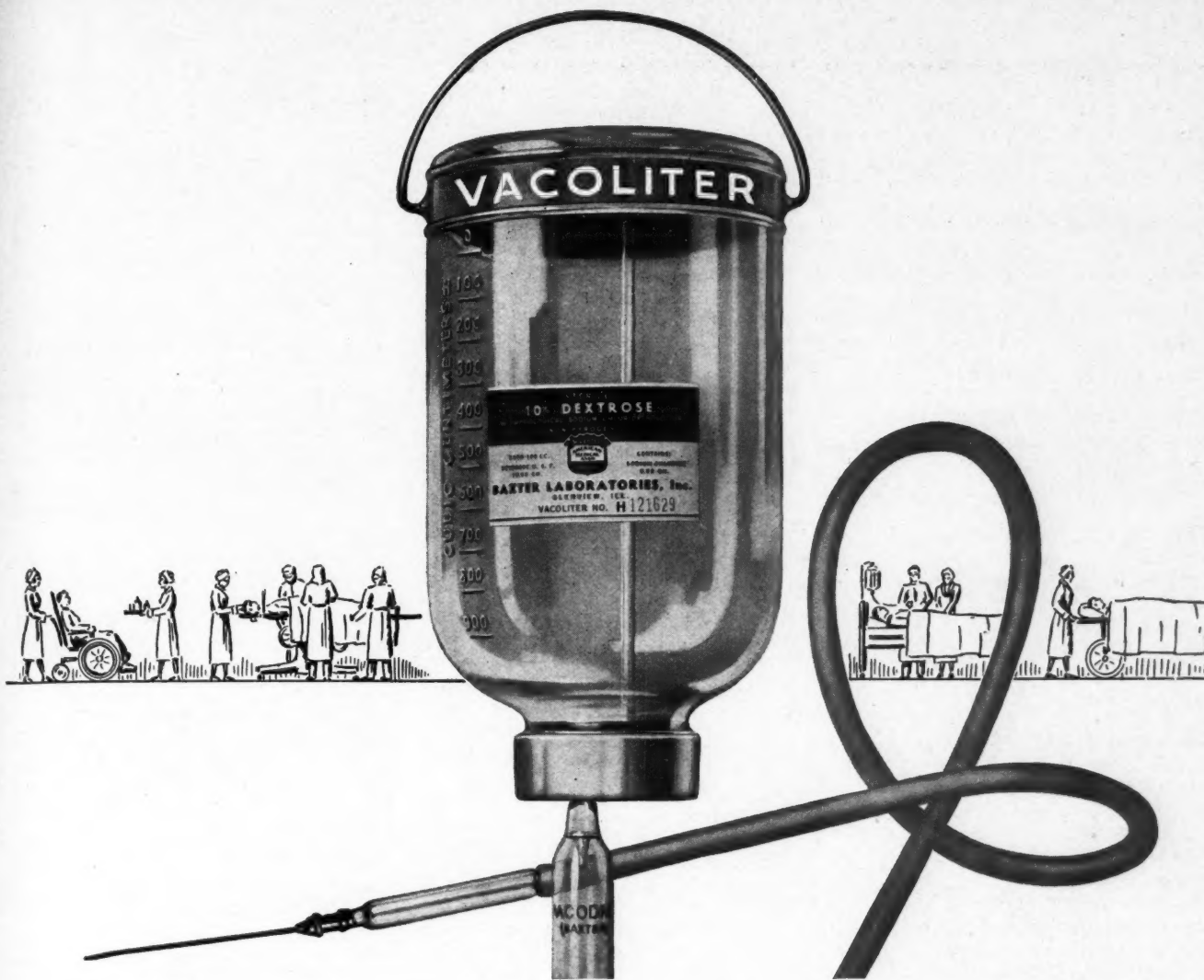
Today refrigeration is of paramount importance and a necessity from the standpoint of economics, health and convenience.\* The need for continuous refrigeration from the time of harvest or slaughter until consumption is becoming more clearly recognized. Careful attention in respect to precooling of products before shipment has doubtless reduced spoilage which is a large factor in our more perishable food supplies.

Food refrigeration still needs and deserves proper supervision. The quality and edibility of foods, and refrigerated foods as well, depend to a great extent upon their physiologic age. The physiologic age in turn depends upon the degree to which the processes of maturation in living materials—such as fruits and vegetables—and the catabolic enzymes contained in dead materials—such as animal products—plus the activity due to bacteria, molds and yeasts they contain, have progressed and the changes which have resulted therefrom.

It must be emphasized that frozen foods, like all other refrigerated foods,



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## IT TOOK US YEARS TO SOLVE SOME OF OUR PROBLEMS . . . . BUT WE SOLVED THEM!

**T**HERE'S peace of mind for you in this statement: *it took us years to solve some of our problems, but we've solved them.*

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require continuous low temperatures to minimize the growth of microorganisms and the biochemical activity of enzymes. Unless low temperatures are maintained, unless the products are about to be used, spoilage will occur and health hazards may result.

It is believed that during the past few years of reduced incomes, the economies of refrigeration have enabled many families to obtain foods in the fresh form during off-seasons at a cost which might otherwise have been prohibited. This has allowed for more complete diets.

In some cases the use of low temperatures is for physical reasons, but in large part it is for the conservation of products against spoilage and the possibilities of injury to the health of the consumer. Refrigeration has been shown to be lethal for various insect pests, including the European corn borer, and has been found effective in killing larvae of trichinella spiralis which are causative agents of trichinosis due to eating pork and its products. It is also recommended as a desirable type of storage for such ingredients as may not be heat treated in manufacture, in transit, in the food shop and in the home.

In 1912 a symposium was held by the American Public Health Association. In this symposium the late Professor Sedgwick made the following statement: "In short, cold storage is one of the greatest boons mankind has ever known. From the sanitary as well as the economic point of view, it is a blessing because it gives us a much greater variety of health-giving food than existed in the older days."

\*Refrigeration of Foods and Its Relation to Present Day Public Health, Am. Pub. Health Ass'n Yrbk., 1935-36. Abstracted by Jane F. Murphy.

### Individualized Nursing Care for the Mentally Ill

A method has been developed over a period of years whereby the nursing care of the psychiatric patient has been individualized to a greater extent than was possible previously.\* Since therapy is administered by the physician personally one hour a day, the purpose of this plan is to enable the physician to prescribe and supervise the management of the patient during the remaining twenty-three hours of each day, thus complementing the direct therapeutic efforts of the physician.

The success of this plan is largely dependent upon its application through carefully trained nurses and therapists whose work is closely supervised and repeatedly checked, therefore the personnel is carefully chosen on the basis of intelligence, interest in the field of psychiatry and stability of personality. Stability of

personality is more important than its type, variations being considered desirable. A thorough psychiatric training course, both didactic and practical, covering a period of three trimesters is given to all new members of the personnel.

Included in the article is a copy of the admission orders in use at the Menninger Sanatorium that show the manner in which the physician, by means of instructions noted under twelve headings, is able to control the activities of each patient. A detailed description is also given of the plan as applied in the treatment of one patient, thus illustrating its use in all cases.

\*Menninger, W. C.: Individualization in the Prescriptions for Nursing Care of the Psychiatric Patient, J. A. M. A., 106:756 (Mar. 7) 1936. Abstracted by N. S. Schlesinger, M.D.

### Examining Foods Microbiologically

Progress toward the standardization and simplification of the microbiologic analysis of food products\* has been made along three lines, namely, for fermented foods, for meats and meat products and for shellfish. Bacteriologists, experienced in the analysis of these types of foods, have assumed leadership in the development of methods for each product.

Dr. C. S. Pedersen agreed to promote methods for sauerkraut, pickles and other fermented products. It seemed advisable to arrange for a series of examinations in various laboratories of both known and unknown samples of fermented foods. Doctor Pedersen prepared an outline of the types of tests he considered important. It was submitted to all members of the committee and others who were in a position to make helpful suggestions. All comments were considered and suggestions incorporated. With a brief introduction and with some sections expanded, this outline will serve as a basis for examination of test samples soon to be submitted to six or eight different laboratories. Preliminary analyses of microflora in fermented foods will be made and later the methods and culture media best suited to the needs can be selected.

The bacteriologic subcommittee of the technical meat committee of the National Canners Association has joined forces with the American Public Health Association in order to make greater progress in the development of methods for examination of meats and meat products. Dr. A. C. Hunter is representing the committee in shellfish examination. The association has been very active in work on oysters.

Many different types of culture media have been used by various bac-

teriologists for the cultivation of anaerobic bacteria. Beef muscle extracts, beef heart extracts, liver infusions, chicken broths and vegetable broths, all including a small portion of the original plant or animal tissue, have been prepared, used and recommended.

Dr. L. S. McClung has carried out an extensive study of the value of different types of culture media. He was particularly interested in thermophilic anaerobes. His survey of various media and methods of producing anaerobic conditions briefly summarizes the information to date, so that his selection of method which is generally satisfactory for the cultivation of anaerobic bacteria is significant. In his study, the sealings of culture tubes with agar proved satisfactory. This method was simple and rapid and it was easier to clean the tubes.

\*Standard Methods for Microbiological Examination of Foods, Am. Pub. Health Ass'n Yrbk, 1935-36, p. 52. Abstracted by Elaine Ehlinger.

### Study of the Death Rate in Maternity Hospital

In a review of 999 fatal cases in the Glasgow Royal Maternity Hospital during ten years, 1925-34, Baird\* found a decreasing death rate, although the maternal mortality for Scotland generally continued to rise. The investigation contrasts two five-year periods, 1925-29 and 1930-34, a change in organization having taken place in 1930. The first period showed a death rate of 2.8 per cent while the second period the rate was 2 per cent. A table gives a complete analysis of the deaths followed by a detailed study of five headings, namely toxemia, sepsis, shock, hemorrhage, and intercurrent disease.

There was a definite improvement in the first two groups. In the toxemia group, eclampsia incidence was reduced by better antenatal care while cases of albuminuria, hyperemesis and pyelitis were admitted earlier and pregnancy terminated earlier by improved technique. The septic cases were reduced by limiting the spread of streptococcus, the wearing of masks and the prevention of contact following normal delivery. Antenatal care has led to the recognition of abnormal cases with consequent earlier admission, thus eliminating prolonged labor. Cesarean deaths have been reduced by the employment of the lower uterine segment operation. In septic abortion cases vaginal packing has been abandoned.

Many of the fatal cases in the shock group were admitted as emergencies, showing the need for earlier recognition of abnormalities. Late chloroform poisoning caused five deaths, emphasizing the need for care in



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choice of an anesthetic. Little improvement was noted in cases of hemorrhage. Placenta praevia deaths were reduced by early diagnosis, prompt cesarean section and extensive use of transfusions. Accidental hemorrhage and post-partum hemorrhage caused an increased number of fatalities. The solution here is difficult, but spacing of pregnancies and the organization of donors is advised.

The intercurrent diseases are ever present, but the earlier admission of cardiac cases and an earlier decision for termination of pregnancy can improve statistics.

The author concludes by stating that in 9 per cent of the fatal cases pregnancy was a grave risk and indicated contraception or sterilization and that birth control methods should be made more available.

\*Baird, Dugald, M.D.: Maternal Mortality in Hospital, *Lancet* 1:295 (Feb. 8) 1936. Abstracted by S. Wimpfheimer, M.D.

## Exploding Popular Fancies in Diets

Unfortunately, a large proportion of the population is unable to discriminate between the claims of ignorant faddists and those of investigators, whose scientific contributions and knowledge have gained for them the position of outstanding authorities.\* One of the most common nutritional fallacies is that proteins and starches are incompatible and should be separated into distinct and separate meals. It is maintained that starches require an alkaline medium for their digestion and proteins an acid medium. Adherence to this system would necessarily eliminate from the diet practically all products made from cereals and grains, such as bread, crackers, macaroni, cakes and pastries. It would also exclude potatoes, beans, peas and many other important foods.

Studies by Rehfuess, Hawk and others on human gastric digestion in the stomach involving more than 1,000 studies on 200 normal men, in which a great variety of protein and starch combinations was used, failed to produce any evidence whatever of the incompatibility of these two classes of food.

Stone has stated that the term acidosis has become a popular fancy. There is no evidence that a preponderantly acid diet is injurious. Arthritis is a disease which is commonly attributed to improper food combinations. Bauer has pointed out that one need make no conscious effort to maintain a basic diet in an arthritic person any more than in a normal one. The prescribing of a low protein diet is a relic from the days when rheumatoid arthritis was confused with gout.

We are told to avoid the use of dark meats or to limit our meat consump-

tion to fish and fowl. With the exception of the glandular organs, liver, sweetbreads and kidneys, dark meat contains no more purine bases than does white meat. Fish and fowl contain as much or more of the uric acid-forming bases as beef, veal, lamb and pork.

It has been proved by numerous investigators that the white of eggs is much less digestible when raw than when cooked. Yet, many physicians and nurses prescribe raw eggs for patients in the belief that they are more digestible and more easily assimilated than when cooked.

Many different systems of dieting and treatments are advocated for weight reduction, some of which are scientifically unsound; others are positively harmful and dangerous. Many reducing menus are erroneously based on elimination from the diet of individual foods, such as potatoes, rice, cereal products and butter. In order to assure an adequate balance of food factors essential for health and normal nutrition, it should be remembered that it is not the kind of food that should be restricted, but the quantity.

It is only by sound principles of nutrition and education that the public can be enabled to avoid fallacies.

\*Food Fallacies and Nutritional Quackery, *Am. Pub. Health Ass'n Yrbk.*, 1935-36, p. 58. Abstracted by Jane F. Murphy.

## Teaching the Medical Student to Be a Physician

The physicians of the United States have given the best medical service in the world.\* The great body of medical practitioners have followed with fidelity the oath of Hippocrates. There is discernible among physicians today a tendency to organize. They are joining their county organizations in great numbers; 100,000 of the 150,000 doctors in the country are affiliated with the American Medical Association. Institutional treatment is replacing home treatment to an ever greater extent, but it appears that only those hospitals supported by taxes are free from the imminence of financial disaster. The question of payment for physicians in such institutions arises; likewise, the effect which such payment will have on private practice. Politics are becoming increasingly important when the future of medicine is considered.

Today the young physician is handicapped by lack of any fundamental knowledge of economics and this is partly due to lack of instruction in medical schools. Teachers tend too much to academic detachment; they have no interest in the general run of physicians; they are indifferent to the personal problems of the students. As citizens, they fail to function. The

young physician should be taught more about public health and practical medicine. Experience at Morrisania Hospital, New York City, shows that the new intern has seldom been taught to approach his patients from the standpoint of practical medicine and that even the spirit of sympathy for suffering is lacking. Hospitals can promote these qualities but training should be begun at the colleges. Without inspirational influence, some young doctors place material gains above service to the sick. Criticism and ostracism will not cure such faults. Correction lies in the hands of those who carry on the teaching of advanced students.

\*Van Etten, N. B.: What Is the Social Objective of the Young Physician, *J. A. M. A.*, 106:772 (Mar. 7) 1936. Abstracted by Viva Schatla, M.D.

## Russia Introduces the Use of Cadaver Blood

The transfusion of cadaver blood was demonstrated in animal experiments and its therapeutic value proved in considerable clinical material at the surgical clinic of the Institute Sklyasovsty, Central Emergency Hospital, Moscow, by the author\* and his assistants. They found that cadaver blood, if obtained from six to eight hours after death, remains sterile and preserves its living properties.

The recipient of cadaver blood is safeguarded by serologic tests of the blood, a bacteriologic check-up as to its sterility, and a careful necropsy. Because of fibrinolysis, the blood of individuals dying suddenly remains fluid and can be preserved for more than three weeks, and the therapeutic effect of cadaver blood does not differ from that of blood from living donors.

The technique of obtaining blood from a cadaver is simple and does not require any special apparatus. The jugular vein is severed and a glass cannula to which a rubber tube is attached is introduced into each end of the vein. The cadaver is then placed in the Trendelenburg position and the blood is allowed to run into a 500 cc. glass flask. The neck of the bottle is stoppered with cotton and the bottle is placed in a refrigerator.

The organization of stations for the collection of fresh cadaver blood should offer no difficulties in the larger cities, particularly in large hospitals for emergency cases. The supply could come from traffic accidents as well as from the medical service where deaths from coronary thrombosis and angina pectoris are not rare. The author's experience with cadaver blood transfusions embraces 924 transfusions, while more than 100 flasks of cadaver blood were sent by his clinic to other hospitals and clinics.

\*Yudin, S. S.: Transfusion of Cadaver Blood, *J. A. M. A.*, 106:997 (Mar. 21) 1936.



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## BOOKS ON REVIEW

**CREATIVE MANAGEMENT.** By Ordway Tead. New York City: Association Press. Pp. 59. \$0.50.

The book is an attempt to call attention to the part that definition of policies and methods of administration play in the success of philanthropic organizations. Aims should be understood and defined on the basis of the social thinking of today. The division of persons into two groups, those who intend "to do good" and those "to whom good is being done," should be a thing of the past.

Philanthropic organizations should recognize that the interest and cooperation of all groups concerned is the corner stone of success. Translated into practical terms, it means the representation of all groups on the board of directors or the executive committee, for example, the influential citizen, the clientele, the staff and personnel.

The executive of the organization is charged by the author with the task of coordinating the necessarily diverse intentions of the board members thus creating unity of effort; of interpreting new problems to the board on the basis of factual material and of delegating the responsibility for carrying out decisions. His functions are discussed under the headings of "Leadership as an Aid to Coordination," "The General Executive and the Board," "The General Executive as Administrator," "The General Executive and His Staff," "The General Executive and Committee Work."

Hospital executives will find it worth while to read Mr. Tead's discussion of the democratic idea of organization and to translate it into terms applicable to hospitals.

The size of the booklet and the inclusion in the discussion of such diverse agencies as the Y. M. C. A. and the hospital should make the reader regard "Creative Management" not as a guide or textbook, but rather as an attempt to stimulate new thinking about the old problem of the aims and functions of philanthropic agencies.—  
GERTRUD KROEGER.

**HANDBOOK FOR THE COLLECTION AND TABULATION OF STATISTICAL INFORMATION ABOUT HOSPITAL IN-PATIENT SERVICE IN THE STATE OF NEW YORK.** Publication No. 17 of the New York State Department of Social Welfare, Albany. Pp. 99. \$0.60.

**HANDBOOK FOR THE COLLECTION AND TABULATION OF STATISTICS FROM DISPENSARIES AND OUT-PATIENT DEPARTMENTS IN THE STATE OF NEW YORK.** Publication No. 18 of the New York State Department of Social Welfare, Albany. Pp. 70. \$0.35.

These two handbooks have been prepared by the division of research and the division of medical care for the use of hospitals in New York State. They represent both a practical and a scientific application of the principles of accounting and statistics recommended by the American Hospital Association. The explanations are clear. The reports are useful and the suggested tabulations permit comparisons of the important aspects of the financial and service data.

Copies of these handbooks may be obtained by groups interested in the collection of financial and service statistics and should be in the hand of every executive concerned directly with comparative statistics, such as an officer of a state or regional hospital association, a community fund or council of social agencies.—C. RUFUS ROREM.



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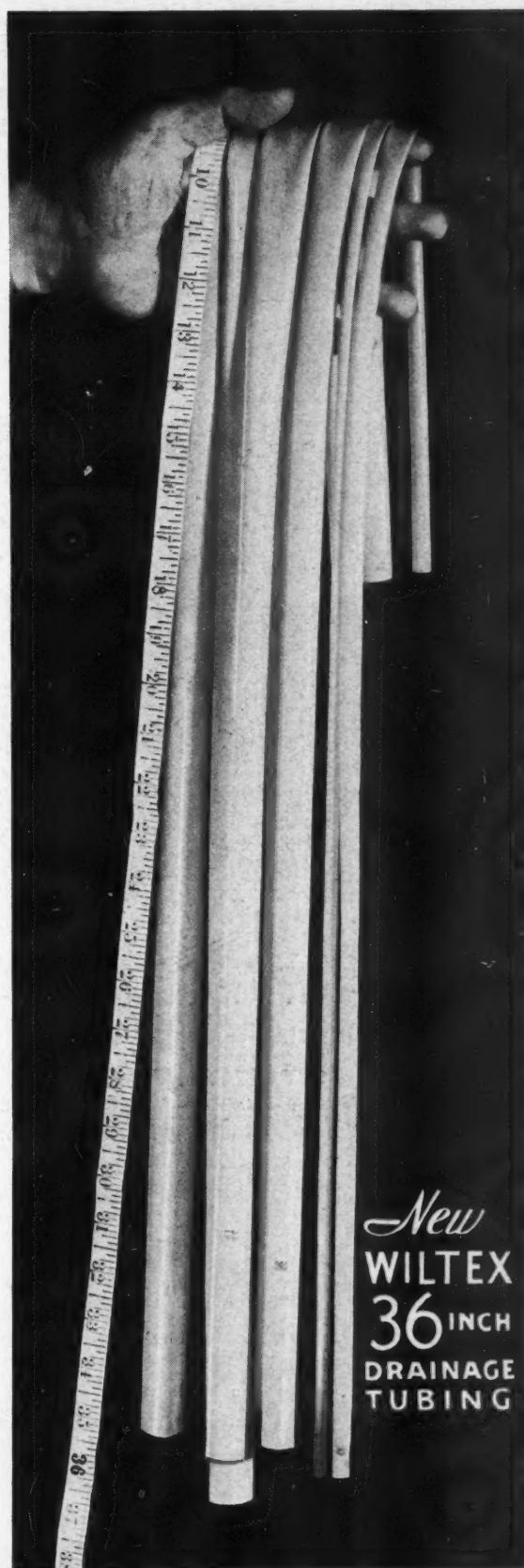
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## NEW PRODUCTS . . .

### Cary Cast Cutter

A news-of-the-month instrument is a fracture accessory developed by Zimmer Mfg. Co., Warsaw, Ind. Its objective—to cut casts with a maximum of efficiency and a minimum of danger to the skin. Its principle of design—that of an oscillating saw with large teeth and oscillated by a handle twelve times as long as the radius of the saw. With comparatively slight effort, a thick, hard cast may be readily cut, one learns. Two sizes, large and small, are noted. An illustrative sheet also includes instructions for use.

### Tear Not—Neither Must We Sew

Pequot Mills, Salem, Mass., nominates for your linen shelf a new double tape selvedge sheet. With twin reinforcement or two parallel strips of selvedge at each edge of the sheet, breaking strength is increased, states Pequot, giving the sheet greater resistance to wear and tear in use and to strain in laundering.

### Under the Big Top

Yes, the gas flame has a circus, or so the story goes, in bringing that new cooking top of the Vulcan range to working temperature and keeping it hot. A radial-fin-cooking-top it is, developed by Standard Gas Equipment Corp., 18 East Forty-First Street, New York City. The radial fins are reputed to soak up heat, to hold it, to distribute it in a wide area around each burner and as a result, to reduce consumption of gas. And there seems more to the manufacturer's story—as there is a large area of hot working surface, one of the new tops will frequently do the work of two ordinary tops.

### A Note on Suction-Pressure Therapy

To make this column a meeting place for notes on new ideas in treatment and new equipment, we report that Burdick Corp., Milton, Wis., recently issued a booklet, "Suction-Pressure Therapy in Peripheral Vascular Disease," which, with certain accompanying abstracted materials, gives the medical profession a résumé of new developments in the use of suction-pressure therapy. Types of obliterative vascular disease, methods of treatment, a brief review of the treatment as a new development, clinical results, technique and a bibliography of articles that have been written on the subject, are important divisions of the new booklet. Presented, too, is the Burdick S-P Unit, with an outline of essential features. Work began on this equipment back in 1932 but the unit was first introduced October, 1935.

### They Call It "Passive Vascular Exerciser"

To make the short story longer, there is a booklet captioned "Taylor presents the Pavaex Passive Vascular Exerciser." Pavaex, by the way, is manufactured by Taylor Instrument Companies of Rochester, N. Y., but distributed solely by Cincinnati Scientific Co., Cincinnati. Indications and contra-indications for this treatment appear in the booklet, as well as a list of "cautions." These follow articles on "The Application of Passive Vascular Exercises



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in Treatment of Obliterative Arterial Diseases of Extremities," and "The Method of Treatment by Passive Vascular Exercises." There are descriptions of the Pavaex unit, itself, and reproductions of charts showing (as historical review) certain important methods of application, also the changes in skin temperature during and after the Pavaex treatment. A bibliography of titles tempts you to read extensively on this subject.

### Trucks and Stretchers That Fold

Truly, you put a truck through its paces when you fold it to fit limited storage space or when, because of its attachments you can make it perform several diverse services. The new Fold-Way truck sold by Continental Hospital Service, Cleveland, is three trucks in one—that is, it may be converted into a linen cart for the laundry, a maid service truck or a general utility truck with shelves. All attachments fit the same chassis. Of importance too, is a new folding wheel stretcher, also trademarked Fold-Way and sold by the afore-mentioned company. With a single operation, it is said, the stretcher is open, ready for use; it locks automatically into open position. Compactly collapsible, it is easily moved through corridors, into elevators or carried in ambulances, and the storage space necessary is reported to be only one-fourth as much as the ordinary truck.

### Now They Are Ninety-six

First-of-month news from Schering & Glatz, Inc., 113 West Eighteenth Street, New York City, informs us that eight dozen Anusol suppositories instead of six dozen as heretofore, will be supplied in a special hospital package. And significant fact, this—the price remains the same.

### A Year's Research Achieves "Luminaire"

Competently done was the research that started early in 1935, that continued without interruption until the first "American Luminaire" was put into operation this last February. Definitely, this month, American Sterilizer Co., Erie, Pa., introduces the new surgical light, claiming for it high degree of illumination with low degree of heat rise per unit of light. Variable field illumination, shadow reduction, color correction, field control adjustment, heat control, light source, dustproof dome construction—these are subjects covered in a booklet just released.

### Quadruplets by Colgate

The Colgate family is larger by four. Briefly, the names and uses of their new soaps are these: Formula 20 is a cold water soap for washing colored fabrics and materials not affected by alkali at low temperatures; Formula 40, a hot water soap, is designed for washing flat white work and fast colored goods; Formula 33 or "PH" control soap, is for use in the "break" operation in power laundering; Formula 91 is a special granular alkali with wide application possibilities—it is utilized in a hospital, for instance, in the dishwashing process. It is said to rinse freely, to leave no residual deposit. Colgate-Palmolive-Peet Co., Jersey City, N. J., will give you supplementary details.

### It Detects Leaks

Comes the new Prest-O-Lite Halide leak detector for refrigerant gases. The Linde Air Products Co., 30 East Forty-second Street, New York City, will supply details covering this supersensitive device said to save time in locating leaks and in avoiding costly equipment shutdowns.



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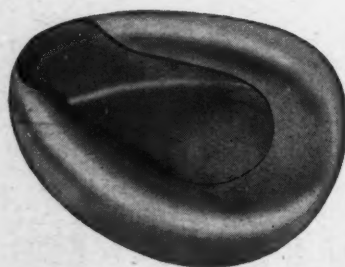
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## Paging New Literature!

**Inhospitable to Moths**—A small swatch folder, lately from L. C. Chase & Co., 295 Fifth Avenue, New York City, offers certain mohair fabrics said to be guaranteed permanently against moths. For one's inspection, there is "Velmo," a mohair velvet for upholstery purposes, and another mohair which is a printed and textured flat fabric for upholsteries and draperies.

**Oculists Only**—Wise in ways of providing equipment and supplies for oculists, Bausch & Lomb Optical Co., Rochester, N. Y., produces a sizable magazine for the optical profession entitled simply, "Bausch & Lomb Magazine." We assume that it is supplied gratis.

**Refrigerators "On the Spot"**—This is just a reminder (for in your magazine reading you have doubtless seen the Frigidaire announcements) that you may have your refrigeration system checked gratis and personally, by a Frigidaire and General Motors representative. Resultant information is noted on a special Check-up Service or Survey Form. Used in conjunction is a new booklet, "Information about Commercial Refrigeration." Helpfully, it gives many hints on proper storage of perishable items.

**Round Casters Fit Square Holes.**—The colorful new catalogue of the Faultless Caster Corp., Evansville, Ind., contains, seemingly, all details essential to an understanding of the ways and workings of casters. One division of the book is devoted to those interchangeable expansion sockets recently introduced by Faultless company to fit round or square metal furniture tubing.

**Aluminum for Hard Chores**—Pots and pans of The Aluminum Cooking Utensil Co., New Kensington, Pa., take on new forms, new uses. Consult that booklet, "Wear-Ever Hospital Operating Room and Room Service Equipment." It reveals instrument sterilizing trays, solution basins and dressing pails for operating rooms; bedside pitchers, drinking cups and related ware for private room and ward work. The new "alumilite" finish, state the makers, is ideal for hospital use since it is smooth, hard, retains its brightness, will not rub off on uniforms, is an aid in corrosion resistance.

**Is This a Cyclopropane Year?**—Communicated from Kansas City last month is the fact that Puritan Compressed Gas Corporation offers to the hospital trade the new Cyclopropane (news about which has been proffered recently by others marketing this anesthetic). "Cyclopropane Gas for Anesthesia" is the title of a small folder bearing the familiar trade mark, "Puritan Maid."

**Up Hill and Down Hill and Into the Farthest Corner**—From Dunbar, W. Va., the Gravely Motor Plow and Cultivator Company reveals in a new folder details about a mower that goes anywhere, cuts anything. Fact is, a swivel-action cutter bar, placed in front of the single-wheel machine enables you, so they say, to mow hillsides and rough places, go into corners or cut close to any object. It is well balanced and easily handled, one is told, and does not get tired as long as it has gas and oil.

**Ice Cream for Dessert**—Timely is the arrival of a new folder on freezer equipment from Tuthill Pump Co., 131 West Sixty-third Street, Chicago. This company makes freezers small and large, the better to satisfy your ice cream requirements. With this equipment, you may also achieve a delicacy termed "frosted malted milk."